Intake Form and Questionnaire

This packet is to be completed by testing patients for Dr. Fraser prior to the first testing appointment.

Patient's Name: _____ Date of Birth: _____

Gender: _____ Date Form Completed: _____

Mailing Address: _____

_____

Primary Phone Number: _____ May we leave a message? _____

Email Address: _____

Form Completed By: _____

Who were you referred by? _____

Primary Care Physician: _____ Phone:_____

Insurance Company: _____ Policy Number:_____

Subscriber Name: _____ Subscriber SSN: _____

Highest Level of Education: _____

Occupation: _____

Primary Language Spoken: _____ Other Languages: _____

Have you previously been evaluated by a previous psychologist? If so when and by whom? _____

_____

General Concerns

What are your primary areas of concern or reason for testing? _____

_____

_____

How long have these behaviors been a concern? _____

_____

_____

What are you hoping to achieve or learn through this process? _____

_____

_____

_____

Medical History

Have you had any other serious illnesses, injuries, or other health problems?

_____

_____

_____

Do you have any allergies? _____

_____

Have you ever been hospitalized? If so, please explain? _____

_____

What is the date of your last physical examination? Any significant results?

_____

Any vision or hearing concerns? _____

_____

Do you wear glasses or hearing aids? _____

_____

Current Medications (name, dosage, frequency): _____

_____

Previous prescription medications (name, dosage, frequency): _____

_____

Have you ever abused drugs or alcohol? If so what substance(s)? _____

_____

What time do you generally go to sleep? _____

What time do you generally awake in the morning? _____

Do you have any sleep difficulties (e.g., frequent night terrors, difficulty falling/staying asleep?) _____

_____

Do you have any dietary restrictions? _____

_____

Family History

Please indicate if anyone in your family has ever had any of these conditions (if so, please specify which family member, such as "mother", "maternal grandmother", "sister").

	Family Member(s)
Delayed walking:	
Delayed talking:	
Speech problems/therapy:	
Learning problems:	
Intellectual disability:	
Autism spectrum disorder:	
ADHD:	
Seizures:	
Cerebral palsy:	
Depression/Anxiety:	
Bipolar disorder:	
Schizophrenia:	
Mental Illness (other):	
Blindness/Visual impairment:	
Deafness/Hearing impairment:	
Death before age 50:	
Heart problems:	
Congenital heart disease:	
Stroke:	
Diabetes:	
Alcoholism or Drug Addiction:	

Behavioral History

What activities do you enjoy doing in your free time? _____

_____

What activities/tasks are most difficult for you? _____

_____

_____

Please check the areas of concern that apply to you:

☐	Short attention span	☐	Peer Problems	☐	Food selectivity
☐	Distractible	☐	Limited imitation skills	☐	Eat non-food items
☐	Hyperactive	☐	Prefers to be alone	☐	Sleep Problems
☐	Impulsive	☐	Poor Eye Contact	☐	Mouth objects
☐	Aggressive	☐	Strong Interests/fixations	☐	Tooth grinding
☐	Destructive	☐	Repetitive Behaviors	☐	Sensory sensitivities
☐	Self-Injury	☐	Ritualistic	☐	Excessive Sexualized Behaviors
☐	Oppositional/Defiant	☐	Need for Routine	☐	High Pain Level
☐	Temper Tantrums	☐	Obsessions	☐	Fearless
☐	Lying	☐	Compulsions	☐	Odd fears
☐	Stealing	☐	Peculiar Habits	☐	Social Anxiety
☐	Cruel to animals	☐	Excessive Laughing	☐	Stranger Anxiety
☐	Fire Setting	☐	Excessive Crying	☐	Separation Anxiety

What time of day do you feel at your best? _____

_____

What time of day do you feel is most difficult? _____

_____

Have you ever been exposed to any form of abuse, neglect or domestic violence? ____

_____

_____

_____

Please submit copies of any of the following if applicable:

1. Previous psychological/psychoeducational testing
2. Relevant Medical Records
3. Treatment Records