Ψ John D. Boyd, PhD, ABPP, ABPH
Licensed Clinical Psychologist

American Board of Professional Psychology American Board of Psychological Hypnosis

Intake Information

The information requested on this form is needed for your treatment. Please complete all items, front and back, and write clearly.

Today's Date: _____

NAME Last: _____ First: _____ MI: _____

DOB: _____ Gender: _____ SSN: _____

Marital Status: Single Married Separated Divorced Other

If Married, how long? _____ If Separated or Divorced, how long? _____

Names & Ages of ALL children _____

_____

Home Address (Street): _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Mobile Phone: _____ Email_____

Emergency Contact: _____ Phone: _____

Name of Employer/School: _____

Employer/School Address (Street): _____

City: _____ State: _____ Zip: _____

Employer Phone: _____

Primary Care Physician and Psychiatrist: _____

Physician Address (Street): _____

City: _____ State: _____ Zip: _____

Physician Phone: _____

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List any allergies or adverse reactions to medicines or other substances: _____

_____

List current diseases and/or disabilities: _____

_____

Current medications (including dosage) you are using and the prescribing doctor:

_____

_____

Date of last medical appointment, doctor's name, reason: _____

_____

List of surgeries and outcomes: _____

_____

Have you ever received previous psychological and/or psychiatric treatment: ___ NO ___ YES

If yes, list provider, kind of treatment, dates, etc.: _____

_____

Have you received previous substance abuse treatment: ___ NO ___ YES

Family History of psychiatric problems, treatment, and substance abuse: ___ NO ___ YES

If yes, briefly describe: _____

_____

Disclosure & Rights: I have received Dr. Boyd's Notice of Privacy Practices and Information About Psychotherapy: _____ (Initial).

Consent for Treatment: I understand that Dr. Boyd is licensed to practice mental health services; I will discuss my particular treatment and its goals with him and by my initials, I hereby consent to the treatment we agree upon: _____ (Initial).

Consent to Communicate: Dr. Boyd has my permission to communicate, written and/or oral, with my primary care physician _____ (Initial) and/or my psychiatrist _____ (Initial).

I understand that missed appointments without 24 hours notice are charged to me, and that use of a credit card carries a convenience fee of 0.4%.

_____ _____

Signature **Date**