

CURT WIDHALM & ASSOCIATES

COUNSELING AND THERAPY

Initial Interview Form

Name: _____ Gender: _____

Home Address: _____

Phone: _____ Message OK: Yes ___ No ___

Alternate Phone: _____ Message OK: Yes ___ No ___

Email Address: _____

Age: _____ Date of Birth: ___ / ___ / ___ Birth Place: _____

Relationship Status: _____ Sexual Orientation: _____

School: _____

School/Work Address: _____

Emergency Contact: _____

Relationship to You: _____

Emergency Contact Phone: _____ Alternate Phone: _____

Please list names and ages of your siblings, if any:

Please describe briefly, the problem(s)/symptom(s) that bring you into counseling: _____

Voice: (818) 826-3557 Fax: (310) 606-3890

Offices in West Los Angeles & Encino

curt@curtwidhalm.com

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Symptoms/Chief Complaints:

Good Fair Poor			Yes No		Yes No				
Sleep:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Restless:	<input type="radio"/>	<input type="radio"/>	Nightmares:	<input type="radio"/>	<input type="radio"/>
Appetite:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Weight loss:	<input type="radio"/>	<input type="radio"/>	Weight gain:	<input type="radio"/>	<input type="radio"/>
Energy level:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Low energy:	<input type="radio"/>	<input type="radio"/>	Hyper:	<input type="radio"/>	<input type="radio"/>
Attention level:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Crying Spells:	<input type="radio"/>	<input type="radio"/>	Sadness:	<input type="radio"/>	<input type="radio"/>
				Depression:	<input type="radio"/>	<input type="radio"/>	Anxiety	<input type="radio"/>	<input type="radio"/>

Suicidal thoughts: Yes No

Homicidal thoughts: Yes No

Have you ever had a problem like this before? [] Yes [] No

If so, when did it happen and how did you deal with it: _____

Have you ever physically harmed anyone? [] Yes [] No

If yes, please specifically explain: _____

Have you ever been arrested for a crime? [] Yes [] No

If yes, please specifically explain: _____

Has anyone in your family (parents, siblings) had a diagnosed psychological or emotional problem? [] Yes [] No

If yes, please specify: _____

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Has anyone in your family (parents, siblings) had a substance abuse problem?

Yes No

If yes, who, what problem, when? _____

Have you ever been in psychotherapy/counseling before? Yes No

If yes, give dates and type: _____

Have you ever been hospitalized for psychological/emotional difficulties or/and eating disorder, alcohol/drugs, surgery or childbirth? Yes No

If yes, give dates and reason: _____

Has any physician ever prescribed medication for psychological problems/emotional difficulties or an eating disorder? Yes No

If yes, who dates and type of medication: _____

Are you currently using any prescribed or non-prescribed medication? Yes No

If yes, name of medication, dosage and reason prescribed: _____

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