CURT WIDHALM & ASSOCIATES
COUNSELING AND THERAPY

Initial Interview Form Children

Name:_____ **Gender:**_____

Home Address:_____

_____

Phone:_____**Message OK:** Yes____No_____

Alternate Phone:_____**Message OK:** Yes____No_____

Email Address:_____

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

School:_____

School Address:_____

_____

Emergency Contact:_____

Relationship to You:_____

Emergency Contact Phone:_____ **Alternate Phone:**_____

Please list names and ages of other people living in the house (including siblings):

_____ _____

_____ _____

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:	( )	( )	( )	**Restless:**	( )	( )	**Nightmares:**	( )	( )
Appetite:	( )	( )	( )	**Weight loss:**	( )	( )	**Weight gain:**	( )	( )
Energy level:	( )	( )	( )	**Low energy:**	( )	( )	**Hyper:**	( )	( )
Attention level:	( )	( )	( )	**Crying Spells:**	( )	( )	**Sadness:**	( )	( )
				Depression:	( )	( )	**Anxiety**	( )	( )

	Yes	No
Suicidal thoughts:	( )	( )
Homicidal thoughts:	( )	( )

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

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

_____

_____

Are there any difficulties at school? [ ] Yes [ ] No

If yes, please describe:_____

_____

_____

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

If yes, please specifically explain: _____

_____

_____

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

If yes, please specify: _____

_____

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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Were there any delays in reaching developmental milestones? [ ] Yes [ ] No

If yes, please describe:_____

_____

_____

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