OC COASTAL COUNSELING
DONNA M. CAROLLO, M.A., LMFT
Couple, Family & Individual Therapy

Intake Information – Child

Name: _____ Date: _____

Address:_____

Phone (Cell):_____ (Home):_____

Which phone would you prefer me to use to contact you?_____

Email: _____ Sex (M/F):_____

Age: _____ Date of Birth:_____ Birthplace:_____

School: _____Grade:_____

Family Information

Parents: _____

Are Parents Married/Separated/Divorced?:_____

Are Parents Living Together?:_____

List Siblings, if any (Names/Ages and if they are half or full siblings):

_____

_____

Chief Reason Child is Seeking Therapy:_____

_____

_____

657 CAMINO DE LOS MARES, SUITE 241,
SAN CLEMENTE, CA 92673
(949)547-2957 PH • (949)498-8824 FAX
WWW.OCCOASTALCOUNSELING.COM
DONNAMCAROLLO@GMAIL.COM

Recent History of Presenting Problem:_____

_____

_____

Developmental History:_____

_____

Social History:_____

_____

Educational History:_____

_____

Medical History:_____

_____

Family Psychiatric History:_____

_____

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Medical Information:

Current Prescribed Medications:

Name: _____ Dose:_____ Frequency: _____

Name: _____ Dose:_____ Frequency: _____

List any other PRNs Used (i.e. aspirin, vitamins):

_____

If child is presently under a doctor or psychiatrist's care, please provide the doctor's name:

Physician's Name:

_____

Psychiatrist's Name:

_____

Emergency Contact (name/relationship/phone):_____

_____

Referral Source (how did you hear about our services?_____

_____

_____ _____

Signature of Parent or Guardian Date

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