

Dr. Raymond F. Castellino

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ADULT INTAKE FORM

Today's Date _____

Name: _____ Licenses and degrees: _____

Birth date: _____ Age: _____ Height _____ Weight _____

Address: _____

Phone: (Home) _____ (Work) _____ (Cell) _____

Fax: _____ Email: _____

Who referred you to us? _____

Profession [or past profession(s) for full time moms]:

What is your intention for doing private session(s) with Ray?

Some of the session activities involve physical exertion. Do you have any medical conditions that would contraindicate involvement in any activity? Yes _____ No _____
If yes, please explain:

Do you have any area of your body that needs special consideration?

Are you presently taking any medications or drugs?
(Please list name of medication, and for what condition you are taking it).

Are you presently using any recreational drugs, alcohol, or nicotine?
(Please list amount per day / week).

What psychological or bodywork training have you had?

What kinds of psychological or bodywork therapy have you experienced and for what period of time?

Are you in therapy or have regular bodywork? Yes _____ No _____ If yes, with whom?
Does this person have pre- and perinatal facilitation skills? Yes _____ No _____

List other physicians or health care practitioners you are being treated by.

Please check what you know or think applies to your birth history:

- _____ an un-medicated vaginal birth in a hospital
- _____ an un-medicated vaginal birth at home
- _____ an anesthesia birth
- _____ with forceps
- _____ with cranial suction
- _____ with fetal heart monitor
- _____ c-section
- _____ breech
- _____ a multiple birth
- _____ other birth complications, please explain.

Please check what you know or think applies to your prenatal and birth history.

- _____ I was premature. How many weeks?
- _____ I was in a Neonatal Intensive Care Unit. How long?
- _____ I was incubated. How long?
- _____ I had a twin that did not live. When in the pregnancy or after did the twin leave?

Where was your father during your birth? _____

Were you separated from you mother at birth (sent to a nursery)? Yes _____ No _____

Were you breast-fed? Yes _____ No _____ If yes, how long? _____

For men: Were you circumcised as an infant? Yes _____ No _____

Please note any interventions shortly after birth such as hospitalization for illness or high jaundice, operations, illnesses as an infant or a child.

Did either or both of your parents lose another child to miscarriage, abortion, stillbirth, or childhood death? If yes, are you aware of how this affected you? Give dates and circumstances.

Who raised you? Were your parents your biological parents? Were you raised by a single parent? If your parents split up, how old were you? Did you have other major primary care givers like grandparents, aunt and uncles, guardians or adoptive parents?

Do you or did you have siblings? List relative ages & nature of relationships as children.

Please relate any other information you know concerning your conception, your parents' attitude toward having you (planned, unplanned, wanted, confused, unwanted). If unwanted, did they consider or attempt abortion?

What do you know about your life in the womb including physical effects (maternal or paternal smoking, drinking, drugs, mom's diet), and emotional effects including absence or presence of father during pregnancy or birth, parents' relationship with each other during your pregnancy, siblings' attitude toward your birth. If you are adopted, give information about transition in hospital and new family as well as any birth history known.

Have you ever lost a child to miscarriage, abortion, stillbirth, or death? Yes ___ No ___
If yes, please explain circumstances and dates and how this affects you today.

Have you ever been or are you in an abusive relationship? Yes _____ No _____
If yes, please state when, what relation the person was or is to you, whether the abuse was or is physical, sexual, and/or emotional. If a past relationship, what action did you take? If present, what are you doing about it? Please give details.

Have you ever been prescribed medications for mental health reason? Yes ___ No ___
If yes, please describe the circumstances and outcomes with dates.

Have you ever been hospitalized for mental health reasons? Yes _____ No _____
If yes, please describe the circumstances and outcomes with dates.

Has anyone in your family ever attempted or committed suicide? Yes _____ No _____
Have you ever contemplated or attempted suicide? Yes _____ No _____
If yes to either, please describe the circumstances with dates.

Signature: _____ Date: _____