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Board Certified Art Therapist, Licensed Mental Health Counselor

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***Information you provide here is protected as confidential information. Please fill out this form and bring it to your initial intake session.

Today's Date: ______
Client's name:____
Age: ______ Date of Birth: ____________ Preferred Gender pronouns: _____________________
Address:____
City: ____ State: Washington Zip code:_________
Home Phone: ___________________________OK to leave of message? _____ YES__________NO
Cell Phone: _____________________________OK to leave a message? ______YES_________NO
Email: __________________________________OK to leave a message? _______YES_________NO
Who referred you: _______________________________________

Name of parent/guardian (if under 18 years of age):
____
Phone number of parent/guardian: ____
Email of parent/guardian: ____

WHOM MAY I CONTACT IN CASE OF EMERGENCY?

Name: ____
Daytime Phone:__________________________________Evening phone:____________________
Relationship to client:____

Current Relationship Status:
__ Single
__ Dating (duration:___)
__ Married (duration:_____)
__ Unmarried, living with partner (duration:___)
__ Separated (duration:_____)
__ Divorced (duration:___)
__ Widowed (duration:___)

Who do you currently live with (name, gender, age, relationship)?

EDUCATION/CAREER:
School:
Total years of education:___
Currently in school:___YES____NO
Grade/Level:___________
Learning difficulties/disabilities?____
Please describe any difficulties or challenges pertaining to school:
____
____
____
Please describe any services/support you receive at school:
____
____

Employment:
Are you currently employed: ___ YES ____NO
Current Employer:____
Job Title:____
Length of time employed:____
Job responsibilities:____
Do you enjoy your job? How stressful is your current job?
____
____
____

Are you involved in any legal activities (civil, criminal, custody, probation/parole, etc.)?
_____YES_____NO

If YES, please describe:
____
____

PRESENTING PROBLEMS/CONCERNS

Describe the issue that led you to seek counseling:

What significant life changes or stressful transitions have taken place recently?

Are you currently taking any medications (including prescription medications, birth control pills, hormones, vitamin, herbs, and supplements)?

If YES, please list type and duration.

Have you received any mental health services (psychotherapy, counseling, psychiatric, etc.) in the past? If YES, where and when? Please describe.

Have you ever been prescribed any psychiatric medication? If YES, please list and provide dates.

Are you currently experiencing any physical limitations or chronic pain?

Please check behaviors and symptoms that occur to you more often than you would like:

- Aggression/fighting
- Alcohol abuse
- Angry outbursts
- Arguments/conflict
- Avoiding people
- Anxiety
- Attention difficulties
- Chest pain/tightening
- Computer addiction
- Depression
- Dizziness
- Drug abuse
- Eating disorders
- Elevated mood
- Emotional outbursts
- Fatigue
- Financial problems
- Gambling
- Hallucinations
- Heart palpitations
- Homicidal thoughts
- Hopelessness
- Impulsivity
- Irritability
- Intrusive thoughts
- Judgement errors
- Learning difficulties
- Loneliness
- Memory problems
- Mood swings
- Panic attacks
- Phobias/fears
- Racing thoughts
- Sleeping problems
- Sexual addictions
- Sexual difficulties
- stress
- Suicidal thoughts
- Worrying

*Please add any other symptoms or behaviors not mentioned.

Briefly describe how the above checked symptoms impair your ability to function effectively:
____
____
____

Have you ever had thoughts or made statements of wanting to hurt yourself or seriously hurt someone else? _____YES______NO.

If YES, please describe the situation:

____

____

Have you ever experienced any?
Emotional Abuse: ____YES_____NO
Physical Abuse: _____YES_____NO
Sexual Abuse: ______YES______NO
Sexual Assault: _____YES______NO

Comments (regarding above statements):

How often do you participate in recreational drug use? (please circle)
Daily
Weekly
Monthly

How often do you consume alcohol? (please circle).
Daily
Weekly
Monthly

Do you consider yourself to be religious/spiritual?

____

____

What are some of your strengths?

____

____

____

What are some of your difficulties/weaknesses?

____

____

____

What do you hope to gain from art therapy/counseling?

____

____

____

How long do you see yourself in therapy?

____