

**Brigid Blume, MA, LMHCA**  
Art Therapist, Licensed Mental Health Counselor Associate  
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**(206)450-9027 (cell/confidential voice mail)**

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

Today's Date: \_\_\_\_\_

Client name: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Name of parent/guardian (if under 18 years of age): \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ OK to leave a message? \_\_\_ YES \_\_\_ NO

Cell Phone: \_\_\_\_\_ OK to leave a message? \_\_\_ YES \_\_\_ NO

Email: \_\_\_\_\_ Ok to leave message? \_\_\_ YES \_\_\_ NO

Who referred you: \_\_\_\_\_

**WHOM MAY I CONTACT IN CASE OF EMERGENCY?**

Name: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

Relationship to Contact: \_\_\_\_\_

**Current Marital Status**

\_\_\_ Single

\_\_\_ Married (duration: \_\_\_\_\_)

\_\_\_ Unmarried, living together (duration: \_\_\_\_\_)

\_\_\_ Separated (duration: \_\_\_\_\_) Divorced (duration: \_\_\_\_\_)

\_\_\_ Widowed (duration: \_\_\_\_\_)

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

**Education/Career:**

**School:** Total years of education: \_\_\_\_\_ Currently in school: \_\_ YES \_\_ NO

**Grade/Level:** \_\_\_\_\_

Learning disabilities/difficulties? \_\_\_\_\_

Please describe any difficulties or challenges pertaining to school:

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Please describe any support/services you receive at school:

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**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?

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

\_\_ YES \_\_ NO

If yes, please describe:

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**PRESENTING PROBLEMS/CONCERNS**

Describe the problem that brought you here today:

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

Are you currently taking any medication (including prescription medications, birth control pills, vitamins, 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:**

<input type="checkbox"/>	aggression/fighting	<input type="checkbox"/>	elevated mood	<input type="checkbox"/>	Loneliness
<input type="checkbox"/>	alcohol abuse	<input type="checkbox"/>	emotional outbursts	<input type="checkbox"/>	memory problems

	angry outbursts		fatigue		mood swings
	arguments/conflicts		gambling		panic attacks
	avoiding people		hallucinations		phobias/fears
	Anxiety		heart palpitations		racing thoughts
	attention difficulties		homicidal thoughts		sleeping problems
	chest pain		hopelessness		sexual addictions
	computer addiction		impulsivity		sexual difficulties
	Depression		irritability		suicidal thoughts
	Dizziness		intrusive thoughts		Worrying
	drug abuse		judgment errors		Financial problems
	eating disorders		learning difficulties		stress

\*Please add any other symptoms or behaviors not mentioned

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

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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:

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Have you ever purposely hurt yourself or another?  YES  NO. If YES, please describe the situation:

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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?

daily          weekly          monthly          infrequently          never

How often do you consume alcohol?

daily          weekly          monthly          infrequently          never

Do you use drugs and/or alcohol to:

Manage stress:          yes      no

Sleep:                      yes      no

Elevate mood:          yes      no

Calm down:              yes      no

Relax:                      yes      no

Control Appetite:          yes      no

Do you consider yourself to be spiritual or religious? If so, please describe.

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What are some of your strengths?

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What are some of your difficulties/weaknesses?

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What do you hope to gain from art therapy?

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