Brigid Blume, ATR-BC, LMHC
Board Certified Art Therapist, Licensed Mental Health Counselor
3400 Harbor Ave SW Suite 401
Mailbox #303
Seattle, WA 98126
(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: _________Preferred pronouns:_______

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 Relationship Status:
__ Single
__ Dating (duration: ______)
__ In a committed relationship (duration:______)
__ 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:
____
____
____

Please describe any support/services 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 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 circle behaviors and symptoms that occur to you more often than you would like:

aggression/fighting	elevated mood	Loneliness
alcohol abuse	emotional outbursts	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:

____

____

____

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 purposely hurt yourself or another? __ 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 use drugs and/or alcohol to:

Manage stress:
__yes __infrequently __no _never

Sleep:
__yes __infrequently __no __never

Elevate mood:
__yes __infrequently __no __never

Calm down:
__yes __infrequently __no __never

Relax:
__yes __infrequently __no __never

Control Appetite:
__yes __infrequently __no __never

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?
____
____
____
____

How long do you see yourself in therapy?
____