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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: _____
Are you enrolled in Medicare?____YES_____NO

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?

_____