Art 4Access

Psychotherapy & Art Therapy services, Consultation & Workshops

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INTAKE FORM

Please note: information you provide here is protected as confidential information.
Please fill out this form and bring it to your first session.

Name: ____
(First) (Middle Initial) (Last)

Birth Date: ______ /______ /______ Age: ________ Gender: □ Male □ Female

Name of parents/guardians (if under 18 years)

____
(First) (Middle Initial) (Last) (DOB)

____
(First) (Middle Initial) (Last) (DOB)

Marital Status (yourself or if child is client – status of each parent currently) :

□ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed □ remarried

□ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed □ remarried

Address: ____
(Street and Number) (City) (State) (Zip)

____
Home Phone: ( ) Cell/Other Phone: ( )

May I leave a message? □ Yes □ No May I leave a message? □ Yes □ No

E-mail: ______________________________ May we email you? □ Yes □ No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Emergency contact ____
(First) (Last) (phone)

Referred by (if any): ____

Please list family members/ages (other than already listed above):

____
(First) (Middle Initial) (Last) (DOB)

____
(First) (Middle Initial) (Last) (DOB)

____
(First) (Middle Initial) (Last) (DOB)

____
(First) (Middle Initial) (Last) (DOB)

____
(First) (Middle Initial) (Last) (DOB)

**if filling out for a minor, please answer for your child*

Have you had previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
□ No
□ Yes, previous therapist/practitioner: ______________________________

Are you currently taking any prescription medication?
□ Yes □ No

Please list: ____

____

Have you ever been prescribed psychiatric medication?
□ Yes □ No

Please list and provide dates: ______________________________

____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)
Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

____

2. How would you rate your current sleeping habits? (please circle)
Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

____

3. How many times per week do you generally exercise? __________

What types of exercise to you participate in? _____________________________________

4. Please list any difficulties you experience with your appetite or eating patterns:

____

5. Are you currently experiencing overwhelming sadness, grief, or depression?

□ No □ Yes

If yes, for approximately how long? ____

6. Are you currently experiencing anxiety, panic attacks, or have any phobias? □ No □ Yes

If yes, when did you begin experiencing this? ____________________________________

7. Are you currently experiencing any chronic pain? □ No □ Yes

If yes, please describe: ____

for 8,9 & 10 if filling out for a child, please note answer is for parents, unless applicable to child

8. Do you drink alcohol more than once a week? □ No □ Yes

9. How often do you engage recreational drug use?

□ Infrequently □ Daily □ Weekly □ Monthly □ Never

10. Are you currently in a romantic relationship? □ No □ Yes
If yes, for how long? ___________________
On a scale of 1-10, how would you rate your relationship? __________

11. What significant **life changes or stressful events have** you experienced?
Please note approximate dates and rate 0-10, how much each impacts you now

**if filling out for a child, answer for them first, then for parents/family*

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FAMILY MENTAL HEALTH HISTORY:

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you/client in the space provided (father, grandmother, uncle, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Rage episodes	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	

1. Are you currently employed? □ No □ Yes
If yes, what is your current employment situation?

____

Do you enjoy your work? Is there anything stressful about your current work?

____

____

2. Do you consider yourself to be spiritual or religious? □ No □ Yes
If yes, describe your faith or belief:

____

3. What do you consider to be some of your strengths? ___________________________

____

____

4. What do you consider to be some of your weakness?___________________________

____

____

5. What are your goals for therapy? ____

____

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