Art Therapy Intake

Therapist: Kari L de Boer, MA, ATR, LPC

Date

Please complete the following form to the best of your knowledge.

Please list patient name, age, and caregiver present if applicable.

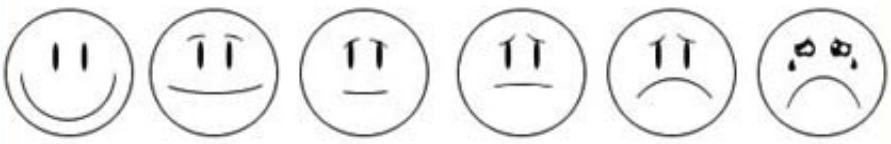
Summarize briefly why you are seeking treatment with art therapy counseling:

What symptoms or problems are most concerning?

When did you first notice the problem? How often does it occur?

Are you currently taking any medications (including over the counter or herbal supplements?

Please circle and state your current mood:



Do you have any serious or chronic medical conditions (including past surgeries)?

Have you had any serious medical accidents, head injuries or seizures?

Have you had any psychotherapy or psychiatric medications before? Hospitalizations?

Do you have any known medication allergies?

How often do you consume coffee, caffeine, alcohol, nicotine, or recreational drugs? Please list what and how often below:

Have you had any legal problems?

Is there a family history of mental illness, substance abuse, or suicide?

Please indicate if you are or have experienced any of the following symptoms:

- ☐ Headaches
- ☐ Bowel trouble
- ☐ Tremors or tics
- ☐ Eating problems
- ☐ Sleep problems
- ☐ Weight gain
- ☐ Feeling apart from others
- ☐ Feeling worthless
- ☐ Thoughts of suicide
- ☐ Crying often
- ☐ Restlessness
- ☐ Mood swings
- ☐ Confusion
- ☐ Excessive spending
- ☐ Irritability
- ☐ Grandiose thoughts/plans
- ☐ Panic attacks
- ☐ Fears
- ☐ Fears of losing self-control
- ☐ Always worried
- ☐ Hearing voices
- ☐ Strange experiences
- ☐ Constant suspicion/distrust
- ☐ Violent behavior
- ☐ Physical abuse
- ☐ Relationship problems
- ☐ Work or school problems
- ☐ Dizziness
- ☐ Pain
- ☐ Drug/ alcohol cravings
- ☐ Binge eating
- ☐ Weight loss
- ☐ Loss of appetite
- ☐ Low energy
- ☐ Memory problems
- ☐ Feeling depressed
- ☐ Unable to enjoy anything
- ☐ Decreased need for sleep
- ☐ Excess energy
- ☐ Elated/euphoric mood
- ☐ Racing thoughts
- ☐ Impulsive behavior
- ☐ Anger/explosiveness
- ☐ Anxiety
- ☐ Nightmares
- ☐ Unwanted thoughts
- ☐ Concentration problems
- ☐ Seeing things others do not
- ☐ Feel others are against you
- ☐ Unusual thoughts
- ☐ Thoughts to harm others
- ☐ Sexual abuse
- ☐ Financial problems

By signing below you are acknowledging the above information is true to the best of your knowledge:

Date:

Date expected completion or reassessment: