rev. [6/16]

Spotted Rabbit Creative Arts Therapy, PLLC

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CREATIVE ARTS THERAPY INTAKE FORM

Client Name:____

Date of Birth: ______________ Age: _________ Social Security #: ________________________

Relationship Status: ___ Single ___ Significant Other ___ Married ___ Divorced ___ Widowed

Who do you share your home with? (significant other, children, roommate/s) ________________

____

Mailing Address: ____

City: ____________________________ State: ______ Zip: ________________

Phone: ____________________ E-mail: ______________________________________

Occupation: ____

____ Full-Time ____ Part-Time ____ Per Diem ____ Disability ____ Retired

Primary Care Physician: ______________________________ Phone: ________________________

Address: ____

Psychiatrist (if applicable): ______________________________ Phone: _____________________

Address: ____

Referred by: ____

Emergency Contact Person:

Name: ____________________________________ Relationship: _________________________

Address: ____

Cell Phone: _______________________________ Home/Work Phone: _______________________

MEDICAL/MENTAL HEALTH HISTORY

Current Medical Conditions/Medications: ____

____

____

____

Previous Mental Health Treatment/Hospitalizations: (please include year) ________________

____

____

____

Substance Abuse History: Do you have a history of alcohol or drug use? ___ Yes ___ No

If yes, please explain: ____

____

Does anyone in your family have a history of problems with alcohol or drugs? ___ Yes ___ No

If yes, who? ____

____

Do you have previous or pending legal charges? ___ Yes ___ No

If yes, please explain: ____

____

History of physical, sexual and/or emotional abuse and/or trauma? ___ Yes ___ No

If yes, please explain: ____

____

Briefly describe your relationship with your family of origin: ___________________________

____

____

____

CURRENT ISSUES

Primary reason(s) for seeking treatment: ____

____

____

What gives you the most pleasure or joy in your life? ____

____

____

What are your main worries and fears? ____

____

____

What are your strengths/interests? ____

____

____

What goals do you have for art therapy? ____

____

____

**formal treatment goals will be developed through a client/therapist collaboration following the initial session(s)*

Is there anything else that is important for me to know as your therapist? ____________________

____

____

Form completed by: ____ **Date:** ________________

Relationship to client: ____