Art for the Heart Counseling

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Adult Intake Form

Name:			
SS #:	**Age:**	**DOB:**	
Ethnicity/Race:	**Religion:**	**Languages:**	
Address:			
Telephone numbers:	**Home:**	**Work:**	**Cell:**
May I leave a message at the above number?	**YES/NO**	**YES/NO**	**YES/NO**
Preferred way to be contacted (circle one):	**Home**	**Work**	**Cell**
May I contact you by E-mail? YES/NO		**Email:**	
How did you hear about Art for the Heart Counseling?		**Do you have any prior experience with Art Therapy?**	

In case of an emergency, who may I contact on your behalf?

Name:	**Relationship:**
Phone Number:	**Address:**

Who are the significant family members in your life? List parents, siblings, step family, and any other significant family members. **Indicate which members you feel particularly close to and supported by.**

Name	**Age**	**Relationship**	**Feel Supported by** **Yes** **No**

Children: (List all children, including biological, adopted, foster, and step children)

Name	**Age**	**Relationship**	**City, State**	**Lives at home?**
				YES/NO
				YES/NO
				YES/NO
				YES/NO
				YES/NO

Do you have a primary care physician? YES/NO	**Physicians name:**
Are you under the care of a psychiatrist? YES/NO	**Psychiatrists name:**

Are you under the care of a specialist? YES/NO					
If yes, please circle type of specialist:					
Cardiologist	Dermatologist	Endocrinologist	Gynecologist	Infertility	Nephrologist
Neurologist	Nutritionist	Occupational Therapist	Oncologist/ Hematoloist	Orthoedic Specialist	Pain Specialist
Physical Therapist	Psychiatrist	Rheumatologist	Sleep Specialist	Urologist	Other:

Please list any chronic illness, disabilities, or medical conditions that you have been diagnosed with:

Illness/Disability	Dates

List all medications you are currently taking:

Medication	**Dosage**	**Treating**

Are you taking the medications according to your doctor's recommendation? YES/NO If No, briefly explain:		

How would you rate your overall sleep at the present time? (poor) 1 2 3 4 5 6 7 8 9 10 (excellent)
Do you exercise on a regular basis? YES/NO **If yes how often?** ____ times per week.
If yes, please briefly describe activity:
How would you rank your overall diet on a scale from 1-10? (poor) 1 2 3 4 5 6 7 8 9 10 (excellent)

Do you drink alcoholic beverages? YES/NO	**If yes how many alcoholic beverages do you drink** ____ weekly ____ daily
Do you smoke? YES/NO	**If yes, how many cigarettes/packs do you smoke?** ____cig./day ____ packs/day
If yes, when did you start smoking?	**Have you ever tried to quit?** YES/NO
Have you in the past or currently: used, abused, or experimented with illegal drugs? YES/NO	**If yes, briefly explain:**

(If applicable) How would you describe your religious or spiritual belief system?
How often do you engage in religious/spiritual practices, ex., praying, attending services, meditating.

Have you ever attempted/seriously contemplated suicide? YES/NO
If yes, describe briefly and indicate dates:

Have you ever had a psychiatric hospitalization? YES/NO
If yes, describe briefly and indicate dates:

Therapy Experiences and Expectations:

Are you currently seeing another therapist? YES/NO
If yes, please indicate the therapist's name:
Have you ever been in therapy in the past? YES/NO
If yes, how would you describe your treatment overall in therapy? Was it helpful?

Therapist	**Location**	**Dates**	**Reason for therapy**

Briefly describe your reason(s) for seeking therapy at this time:

What goals do you wish to accomplish during the therapy process?

Is there anything else you would think would be important for me to know about you?