The Light of The Heart A Community Art Therapy Project

Adult Intake Form

<u>Contact Information & Demographics</u>

Name:____ Date: ____________

Address: ____

City:____ Zip Code:_______________

Phone Number:__________________________________

Referred by: ____

Have you been court-ordered for therapy? Yes No

Date of Birth: ________________________

I identify as:
Please circle one
Male Female Transgender Other, please specify: __________________

I am:
Please check the appropriate box
□ American Indian or Alaska Native
□ Asian
□ Black or African American
□ Caucasian or White
□ Hispanic or Latino
□ Native Hawaiian or Other Pacific Islander
□ Other, please specify: ______________________

What is your marital status? ________________________

What is the highest level of education you attained?
(1) Elementary school or middle high/junior high school
(2) Graduated from high school or received G.E.D.
(3) Received vocational/technical training
(4) Some college
(5) Graduated from a 4-year college
(6) Received a master's or post-graduate degree
(7) Received a doctoral degree (Ph.D., M.D.)

Place of Employment: ____
Position/Title: ____
Annual Household Income: ____

Number of Children: _________________ Ages: _________________________

Please list the people in your household: ____
____
____
____

Health History

Describe your reasons/goals for requesting services:
____
____
____
____

Which of the following kinds of behavioral health services have you received prior to coming here? *Please circle all that apply*

(1) None
(2) Outpatient therapy
(3) Partial care
(4) Inpatient care
(5) Other:_____________________________

How many times have you received behavioral health services prior to coming here?

(1) None
(2) 1 - 2
(3) 3 - 4
(4) 5 or more, but fewer than 10
(5) 10 or more

Have you experienced any of the following?
Please circle all that apply

Anxiety
Depression
Extreme mood swings
Alcohol or drug abuse
Unusual thought or beliefs
Learning disability
Self-inflicted pain or injury
Social isolation
No appetite
Always tired
Unable to relax
Recurrent dreams
Hallucinations
Feel tense
Obsessions
Suicidal ideas
Can’t make friends
Poor living conditions
Always worried about something
Can’t make decisions

Physical Abuse
Eating Disorder
Criminal behavior/incarceration
Aggression/violence
Overwhelming crisis
Recurrent conflicts with others
Sexual problems
Mental/Emotional/Verbal Abuse
Over-eating
Sexual Abuse/Assault
Insomnia
Nightmares
Inferiority feelings
Panic Attacks
Gambling
Shy with people
Afraid of people
Unable to have a good time
Don’t like weekends/vacations
Over-ambitious

Financial problems
Job problems
Fears and phobias: ____________________

Internet Addiction
Bullying
Other ________________________

What mental health diagnoses have you received?
____
____

If you have ever attempted suicide, when was your most recent attempt?
(1) Never attempted suicide
(2) Within the last month
(3) More than 1 month ago, but within the last year
(4) More than 1 year ago, but less than 5 years ago
(5) More than 5 years ago

Has any other member of your family previously sought or received psychological or psychiatric counseling?
(1) No (2) Yes, if yes, who: ______________________________

Has anybody else in your family experienced any of the following problems?
Please circle all that apply
(1) Anxiety
(2) Depression
(3) Extreme mood swings
(4) Alcohol or drug abuse
(5) Unusual thoughts or beliefs
(6) Learning disability
(7) Developmental delays
(8) Suicide
(9) Criminal behavior/incarceration
(10) Aggression/violence
(11) Attention deficit disorder
(12) Other mental health problem

Have you had a physical examination within the last six months? No Yes

Have you seen a physician or other health care professional within the last six months for reasons other than a physical checkup? No Yes
If yes, please specify reasons: ____
____

Please circle any of the following that you have experienced either currently or in the past:
(1) Headaches
(2) Dizziness
(3) Fainting spells/blackouts
(4) Severe or prolonged nausea
(5) Seizures or convulsions
(6) Memory loss
(7) Allergies
(8) Asthma
(9) Ulcers
(10) High blood pressure
(11) Thyroid difficulties
(12) Diabetes
(13) Hypoglycemia (low blood sugar)
(14) Heart disease
(15) Other heart condition: _________________________

What medical diagnoses have you received?
____
____

Please describe major illnesses, surgeries and/or serious injuries and approximate dates:

____

____

____

Please list current drugs or medications, average dose, and frequency:

____

____

____

Who is currently monitoring your medication:

____

If there are any other medical or physical problems, which you feel might be important to my ability to be of help you, please explain here:

____

____

____

Who is your current physician? ____

Anything else you would like to share?

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____

Art Materials

What type of art materials do you enjoy using?

____

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