Art of Therapy Center
A holistic approach to therapy with families.

Intake Questionaire

Patient Information

Name:_____
Date of Birth:_____
Date of Appointment:_____
Who referred you to our center? _____
In your own words, why were you referred to our center?

_____
_____
_____
_____
_____

Tell us a little about you and your family!

Have you ever been diagnosed with any of the following:

- ☐ ADHD
- ☐ Anxiety
- ☐ Depression
- ☐ Major Depression
- ☐ Bipolar Disorder
- ☐ Self Harm
- ☐ Reactive Attachment Disorder
- ☐ Hearing Impairments
- ☐ Visual Impairments
- ☐ Autism Spectrum Disorder
- ☐ Sensory Processing Difficulties
- ☐ Heart Disease
- ☐ Seizures
- ☐ Diabetes
- ☐ Thyroid Problems

If yes to any, please elaborate on who and when: _____

_____
_____
_____

Has anyone in your family (your children, your parents, grandparents, aunts and uncles) ever been diagnosed with any of the following:

- ☐ ADHD
- ☐ Anxiety
- ☐ Depression
- ☐ Major Depression
- ☐ Bipolar Disorder
- ☐ Self Harm
- ☐ Reactive Attachment Disorder
- ☐ Hearing Impairments
- ☐ Visual Impairments
- ☐ Autism Spectrum Disorder
- ☐ Sensory Processing Difficulties
- ☐ Heart Disease
- ☐ Seizures
- ☐ Diabetes
- ☐ Thyroid Problems

If yes to any, please elaborate on who and when: _____

_____

_____

_____

Basic School Information

Are you currently enrolled in School? ☐ YES ☐ NO
If yes, which school do you attend? _____
What grade are you in? _____
Have you ever repeated a grade? ☐ YES ☐ NO
If yes, which grade and why?_____
What does your child's teacher say about him/her?

_____

_____

_____

_____

_____

Other schools attended (including pre-school):

_____

_____

_____

Do you have a 504 or IEP? ☐ YES ☐ NO
Has your child ever received special education services?

_____

_____

Has your child experienced any of the following problems at School?

- ☐ **Fighting**
- ☐ **Lack of friends**
- ☐ **Drugs/Alcohol**
- ☐ **Detention**
- ☐ **Suspension**
- ☐ **Learning Disabilities**
- ☐ **Poor attendance**

- ☐ **Poor grades**
- ☐ **Incomplete homework**
- ☐ **Distractibility**
- ☐ **Gang influence**
- ☐ **Behavior problems**

Family History

Mother's Name:_____
Mother's Address:_____

Father's Name:_____
Father's Address: _____

Do you have any Siblings? ☐ YES ☐ NO

Brothers AND their ages: _____
_____
_____

Sisters AND their ages: _____
_____
_____

Who do you live with?
_____

Is there an active Custody Agreement? ☐ YES ☐ NO
If yes, please explain custody order:_____
_____
_____
_____
_____

**Please note, if there is a custody agreement filed with the courts, our office will need an official copy of this order before services can begin. **

Has law enforcement or DSS ever been involved with your family? ☐ YES ☐ NO
If yes, please explain situation and outcome:_____
_____
_____
_____
_____

What is the name of your child's primary care physician? _____
Address: _____ **Phone:** _____
Date of your child's last medical examination: _____

Did the child's mother smoke tobacco or use any alcohol, drugs or medications during the pregnancy? If so, please list which ones:

Did the child's mother have any problems during the pregnancy or at delivery? If so, please describe them:

Has your child experienced any of the following medical problems?

- ☐ **A serious accident**
- ☐ **Hospitalization**
- ☐ **Head injury**
- ☐ **Surgery**
- ☐ **Asthma**
- ☐ **High Fever**
- ☐ **Convulsions/Seizures**
- ☐ **Eye Problems**
- ☐ **Ear Problems**
- ☐ **Meningitis**
- ☐ **Hearing Problems**
- ☐ **Allergies**
- ☐ **Loss of Consciousness**

Other Medical conditions:

Please list any current medical problems or physical handicaps:

Please list any medications your child takes on a regular basis:

Who are other household members with your child?

Names	Ages	Relationship to child

Who are your child's significant others NOT living with your child?

Names	Ages	Relationship to child

Behavioral Excesses

What does your child currently do too often, too much, or at the wrong times that gets him/her in trouble? Please list all the behaviors you can think of.

Behavioral Deficits

What does your child fail to do as often as you would like, as much as you would like, or when you would like? Please list all the behaviors you can think of.

Behavioral Assets

What does your child do that you like? What does he/she do that other people like?

Other Concerns

Do you have any other concerns about your child or your family that you have not mentioned yet?

Treatment Goals

From your preceding list of your child's behavior and your family concerns, what problem behaviors do you want to see change FIRST: and how much must they change for you to be satisfied?

Please describe any past counseling that either your child or any family member

Does anyone in the child's family use currently (or in the past) any type of drug, tobacco, or alcohol? ☐ Yes ☐ No
If yes, please describe:

Other History

Has your child ever experienced any type of abuse (physical, sexual, or verbal? If so, please describe:

Has your child ever made statements of wanting to hurt him/herself or seriously hurt someone else?

Has he/she ever purposely hurt himself or another? If yes to either question please describe the situation:

Has your child ever experienced any serious emotional losses (such as a death of or physical separation from a parent or other caretaker)? If yes, please explain:

Finally, what are some of the things that are currently stressful to your child and his/her family?