



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

## INTAKE QUESTIONNAIRE

### 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?

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### TELL US A LITTLE ABOUT YOU AND YOUR FAMILY!

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

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> ADHD             | <input type="checkbox"/> Reactive Attachment Disorder | <input type="checkbox"/> Sensory Processing Difficulties |
| <input type="checkbox"/> Anxiety          | <input type="checkbox"/> Hearing Impairments          | <input type="checkbox"/> Heart Disease                   |
| <input type="checkbox"/> Depression       | <input type="checkbox"/> Visual Impairments           | <input type="checkbox"/> Seizures                        |
| <input type="checkbox"/> Major Depression | <input type="checkbox"/> Autism Spectrum Disorder     | <input type="checkbox"/> Diabetes                        |
| <input type="checkbox"/> Bipolar Disorder |   | <input type="checkbox"/> Thyroid Problems                |
| <input type="checkbox"/> Self Harm        |   |  |

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

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## INTAKE QUESTIONNAIRE

### 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

Drugs/Alcohol

Suspension

Lack of friends

Detention

Learning Disabilities



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## INTAKE QUESTIONNAIRE

- Poor attendance
- Poor grades
- Gang influence
- Incomplete homework
- Behavior problems
- Distractibility

### 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:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



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## INTAKE QUESTIONNAIRE

**\*\*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:

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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:

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

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## INTAKE QUESTIONNAIRE

Has your child experienced any of the following medical problems?

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> A serious accident | <input type="checkbox"/> High Fever           | <input type="checkbox"/> Hearing Problems      |
| <input type="checkbox"/> Hospitalization    | <input type="checkbox"/> Convulsions/Seizures | <input type="checkbox"/> Allergies             |
| <input type="checkbox"/> Head injury        | <input type="checkbox"/> Eye Problems         | <input type="checkbox"/> Loss of Consciousness |
| <input type="checkbox"/> Surgery            | <input type="checkbox"/> Ear Problems         |  |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Meningitis           |  |

Other Medical conditions:

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Please list any current medical problems or physical handicaps:

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

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Who are other household members with your child?

| Names | Ages | Relationship to child |
|-------|------|-----------------------|
|-------|------|-----------------------|

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## INTAKE QUESTIONNAIRE

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?

|       |
|-------|
| _____ |
| _____ |



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### OTHER CONCERNS

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

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### 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?

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

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## INTAKE QUESTIONNAIRE

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:

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### OTHER HISTORY

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

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

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

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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:

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

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