Quinn Art Therapy, PLLC

CHILD/ADOLESCENT/FAMILY INTAKE FORM

Intake Date: _____

I. Client(s) Information:

CONTACT: _____ **GENDER:** _____

DATE OF BIRTH/PLACE: _____ **AGE:** _____

ADDRESS: _____

_____

PHONES: **Home:** _____ **Cell:** _____

Work: _____ **FAX:** _____

FOR ROUTINE MESSAGES: Phone #_____ **E-mail:** _____

FOR CONFIDENTIAL MESSAGES: Phone #_____ **E-mail:** _____

EMERGENCY CONTACT INFORMATION:

NAME: _____ **PHONE:** _____

All participating family member name(s):

Client name(s):
DOB: **Age:**
Primary Language: **Secondary Language:**
Ethnicity:
School: **Grade:**

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DOB: **Age:**
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DOB: **Age:**
Primary Language: **Secondary Language:**
Ethnicity:
School: **Grade:**

Referred By:

Person or Agency Name:

Phone #

Parent's Name:

Name of Spouse or Partner:

Legal Guardian/Foster Parent's Name:

Address:

Phone:

If Applicable, Informant or Translator Name:
Relationship to client or family:
Language:

Why was child, adolescent, or family referred for art therapy?

Current symptoms and behaviors:

Onset & Duration:

II. Symptoms/Behaviors/Presenting Problem History

How are the symptoms a problem?

Parent/Guardian/Caregiver perception of cause:

Attempted interventions and responses:

Relevant Factors?
Environment (School/Home):

Relationships (Loss/Separation):

Traumatic Events:

Sexual or physical abuse:

Sleep Patterns:

Eating Patterns:

Hygiene Changes:

Peer Problems:

III. Prior Mental Health History

Suicidality or Homicidality?

Previous Therapy Interventions?

When:

Where:

(Previous Therapy Interventions)

Type:

Duration:

Parent and Child Satisfaction with previous therapy treatment?

Medication(s)?

Dosage

Response or adverse reactions:

IV. Medical History:

Illness (Acute/Chronic)?

Medications?

Allergies?

Accidents?

Head Injuries?

(Medical History)
Seizure?

Pregnancy?

Sexually Transmitted Diseases?
HIV?

Vaccinations?

Hospitalizations/Surgeries?

Vision/Hearing?

Dental Health?

Pediatrician name:

Phone:

Last Exam:

Doctor name:

Phone:

Last Exam:
(Medical History)
Glasses or Braces?

Substance Abuse?

Child admitted to parents their drug/alcohol use or abuse?

Parents discussed drug/alcohol abuse and consequences with child?

V. Developmental History

Indicate for each child:
Prenatal Care received?

Full Term birth?
Or, how many months:

Birth Weight:

Place of delivery:

Parents at time of birth:
Age of mother:

Age of father:

Marital Status at the time:

Did mother use alcohol, cigarettes, drugs during pregnancy:

Any illnesses, accidents, or relational stressors during pregnancy or at the time of birth:

Type of Delivery:

Duration of Labor:

Post partum complications?:

Developmental Milestones (Describe or WNL for within normal limits):
Infancy (0-3)
Motor - sit, crawl, walk; Speech; Eat; Sleep; Toilet training; Coordination; Temperament; Separation:

Early Years (4-6)
Social adjustment; Separation; Sexual behaviors; Self-Care:

Latency (6-11)
School adjustment; Peer & adult relations/friends; Interest/Hobbies; Impulse control; Self-Care:

Adolescence (12 and up)
Separation/Individuation; Sexual identity/behavior; Relationships; Independent functioning; Moral development:

Environmental and Incidental Stressors such as moves; schools; separation; losses of fam/friends, changes in family composition, SES, lifestyle; exposure to family conflict/violence; major illnesses; abuse; placements, etc.

VI. School History

Type of School:

Academic Performance:

Special Education?

Current or past IEP Date:

Grade Retention?

Age and Grade Level:

Change of School?

Age and Grade Level:

Child, adolescent, and parents attitudes about school:

Truancy issues:

Suspension(s):

Juvenile Court History?

Arrests/Offenses?

Tickets/Warnings?

DCFS or Police Intervention at school or home?

Parents response:

Child Abuse & Protective Services Intervention at school or home?

Parents response:

VII. Family History & Current Living Situation

Nature of family group being described: Biological, Adoptive Guardian, Foster, Blended:

Family Composition:

Marital Status:

Grandparents:

Ethnicity/Culture:

Parents Education:

Parents Occupation:

Socio-Economic Status:

Family Patterns and History

Medical:

Psychiatric:

Alcohol/Drug:

Legal/Criminal:

Family Relationships (current and intergenerational; easy, strained, or broken):

Disciplinary Style:

Conflict/Violence:

Family Strengths as perceived by members:

Family/Child's perceived needs and expectations within the context of their culture:

What are you and children expecting of art therapy treatment?

What are you willing to contribute to the therapy process?

Intake Completed By: _____

Signature

_____

Print Name

Client Name:

Date of Completion: _____