Quinn Art Therapy, PLLC
Theresa Quinn, M.A., ATR, LMFT

Biographical Information-Intake Form

Please fill out this biographical background form as completely as possible. It will help me in our work together. Information is confidential as outlined in the Office Policy form and the HIPAA Notice of Privacy Practices. If you do not desire to answer any question, merely write, "Do not care to answer." Please print or write clearly and bring it with you to the first session.

DATE :___________________________________

NAME: ____ **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:** _________________________

REFERRAL SOURCE: ____

PRESENTING PROBLEM (be as specific as you can: when did it start, how does it affect you…):

____

____

____

____

____

____

Estimate the severity of above problem (circle): Mild – Moderate – Severe - Very severe

OCCUPATIONS (former, if retired, laid off, or currently unemployed, if Military service):

____

____

____

HIGHEST GRADE/DEGREE: ____________________ TYPE OF DEGREE: ________________

CURRENTLY: Married:_____ Life Partner:_____ Live with Someone:______ Dating: __________

Name: ____ Years Together: ________________

Education: _________________________________ Occupation: __________________________

PAST & PRESENT MARRIAGE/S (years together, names & statement about the nature of the relationship/s, i.e., friendly, distant, physically/emotionally abusive, loving, hostile):

____

____

____

____

____

DOMESTIC VIOLENCE INFORMATION (IF "YES" PLEASE BRIEFLY DESCRIBE):

Frequency of conflicts & the manner in which they are resolved with spouse or partner/ex partner?

____

____

Interrogation about, or restriction of, outside activities/associations/friends by you or partner/ex?

____

____

Name-calling, insults, threats by clt. or partner/ex-, when angry?

____

____

Does clt. or partner/ex- have an explosive temper or difficulty controlling anger?

____

____

Hitting, shoving, kicking or throwing of objects by you or partner when angry?

____

____

Have you or partner/ex- ever required medical treatment as a result of domestic violence?

____

DOMESTIC VIOLENCE INFORMATION (IF "YES" PLEASE BRIEFLY DESCRIBE):

Has law enforcement ever been involved because of fighting or domestic violence?

Do you or partner own a weapon? If yes, describe weapon, location, frequency & purpose of use:

CHILDREN/STEP/ADOPTED/GRAND (names/ages, brief statement on your relationship)

1.

2.

3.

4.

5.

PARENTS/CAREGIVERS (Name/age or year of death/cause of death, occupation, personality, how did s/he treat you, brief statement about the relationship):

Father:

Mother:

Steparents:

Foster/Kin/Residential/Other Care:

____

SIBLINGS (name/age, if dead: age and cause of death & brief statement about the relationship):

1.____

____

2.____

____

3.____

____

4.____

____

5.____

____

DESCRIBE YOUR CHILDHOOD IN GENERAL (Relationships with parents, siblings, others, school, neighborhood, relocations, any school/behavioral/problems, trouble with the law, abusive/alcoholic parent):

____

____

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____

IF PARENTS DIVORCED: Your age at the time: ______, Describe how it affected you at the time

____

____

____

____

____

SEXUAL HISTORY (Sexual orientation, sex education, childhood-adult sexual problems, unmet needs):

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____

____

____

____

MEDICAL DOCTOR/S (name /phone): ____

____

____

____

PAST/PRESENT MEDICAL CARE (major medical problems, surgeries, accidents, falls, illness):

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____

____

____

WHAT MEDICATION(S) are you presently taking and for what. PRINT clearly:

____

____

____

____

PAST/PRESENT DRUG/ALCOHOL USE/ABUSE (AA, NA, treatments, recreational use)**:**

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____

____

FAMILY MEDICAL HISTORY (Describe any illness that runs in the family: cancer, epilepsy, etc)**:**

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____

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____

PAST/PRESENT PSYCHOTHERAPY (specify: month/year to month/year, # of sessions, name, degree, phone & address of therapist, reason for therapy, Ind/Couple/Family treatment, medications, brief description of the treatment relationship and how helpful it was, and how/why it ended)**:**

1. ____

____

____

2. ____

____

PAST/PRESENT PSYCHOTHERAPY (specify: month/year to month/year, # of sessions, name, degree, phone & address of therapist, reason for therapy, Ind/Couple/Family treatment, medications, brief description of the treatment relationship and how helpful it was, and how/why it ended)**:**

3. ______

4. ______

SUICIDE ATTEMPT/S or **VIOLENT BEHAVIOR** (describe: ages, reasons, circumstances, how, etc)

PSYCHIATRIC HOSPITALIZATIONS (When, why, for how long, diagnosis)

FAMILY HISTORY OF ALCOHOLISM, MENTAL ILLNESS, OR VIOLENCE (including suicide, depression, hospitalizations in mental institutions, abuse, incarceration):

ARE YOU INVOLVED IN ANY CURRENT OR PENDING CIVIL OR CRIMINAL LITIGATION/S, LAWSUIT/S OR DIVORCE OR CUSTODY DISPUTE/S? (if you answer Yes, please explain):

FRIENDSHIPS, COMMUNITY, SPIRITUALITY (religion, spirituality, activities, support system):

WHAT GIVES YOU THE MOST JOY OR PLEASURE IN YOUR LIFE?

WHAT ARE YOUR MAIN WORRIES AND FEARS?

WHAT ARE YOUR MOST IMPORTANT HOPES OR DREAMS?

WHAT ELSE WOULD YOU LIKE ME TO KNOW ABOUT YOU AND YOUR SITUATION?