

Denver Art Therapy & Counseling, LLC

BIOGRAPHICAL INFORMATION-INTAKE FORM (Adolescents)

Today's Date _____

CLIENT INFORMATION					
Client's Last Name	First	Middle	Title	Marital Status	
Is this client's legal name?	If not, what is the legal name?		Birth Date	Age	Sex
Yes No			/ /		
Street Address	City	State	Zip Code	Home Phone Number	
				()	
P.O Box	City	State	Zip Code	Cell Phone Number	
				()	
Grade	School			Work Phone Number	
				()	
Referred By:	Website	Google	Other: _____		
Psychology Today	Family	Friend	_____		
Email Address:			Alternative Email Address:		
PAYMENT INFORMATION		Please hand insurance card to Office Manager			
Person Responsible for Bill	Birth Date	Address		Home Phone	
	/ /			()	
Email Address				Cell Phone	Phone
				()	
Occupation	Employer	Employer	Address	Work Phone	Phone
				()	
Is this client covered by Insurance?	What is the name of your insurance provider?				
Primary Insured's Name	Insured's Social Security	Birth Date	Group #	Policy #	Co-Pay
	- -	/ /			
Client's relationship to Insured	Self	Spouse	Child	Other:	

Please add on the other side of the page or on a separate page any other information you would like me to know about you and your situation.

Name of Secondary Insurance(If any)	Insured's Name	Group #	Policy #		
Client's relationship to Insured					
Self		Spouse		Child	
Other:					
IN CASE OF EMERGENCY					
Name of Local Friend or Address	Relative (Not living at same	Relationship to Client	Home Phone Number	Cell Phone Number	Work Phone

ADDITIONAL PEOPLE LIVING IN THE HOME:

NAME: RELATIONSHIP TO CLIENT: AGE/OCCUPATION: PHONE/EMAIL:

OTHER PEOPLE CLOSELY INVOLVED WITH CT. NOT LIVING IN THE HOME:

NAME: RELATIONSHIP TO CLIENT: AGE/OCCUPATION: PHONE/EMAIL:

CONCERNS THAT BROUGHT CT. TO THERAPY: (be as specific as you can: when did it start, how does it affect you...):

Estimate the severity of above problem: Mild-Moderate-Severe-Very severe

ADDITIONAL CONCERNS:

Quality of Sleep (nightmares, difficulty, etc) : _____

Enuresis or Encopresis: _____

Eating Habits (Recent Changes?): _____

Academic Difficulties: _____

Please add on the other side of the page or on a separate page any other information you would like me to know about you and your situation.

Difficulties with peers: _____

Inappropriate Sexual Behavior: _____

Poor Self-Esteem: _____

Lies/Steals: _____

Noncompliant: _____

RISK OF HARM: Impulse to hurt self or others, Suicidal Ideation, Cutting, Cruelty to Animals

CURRENT SAFETY CONCERNS (IF YES, CREATE SAFETY PLAN): yes _____ no _____

FAMILY HX:

IF PARENTS DIVORCED: Child's age at the time: _____, Describe how you think it affects child. _____

PARENTS/STEP-PARENT (Name/age or year of death/cause of death, occupation, personality, brief statement about the relationship):

Father: _____

Mother: _____

Step-parents:

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

1. _____

2. _____

3. _____

4. _____

5. _____

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

Serious Illness: _____

Mood Disorders: _____

Anxiety/Depression: _____

Other Psychological Concerns: ADHD/ OCD/ Eating Disorder/: _____

Please add on the other side of the page or on a separate page any other information you would like me to know about you and your situation.

Substance Abuse: _____

Violent Behavior: _____

CLIENT DEVELOPMENTAL AND MEDICAL HX:

Developmental Concerns with Regard to Pregnancy/ Birth/ Early Childhood:

MEDICAL DOCTOR/S (name /phone): _____

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

SPECIFY MEDICATION child is presently taking, dosage, reason. PRINT clearly:

ALLERGIES _____

PAST/PRESENT PSYCHOTHERAPY (specify: month year/s (beginning—end), estimated no. of sessions, name, degree, phone & address, initial reason for therapy, Individual/Family, medication, brief description of the relationship and how helpful it was, and how/why it ended):

1. _____

2. _____

USE OTHER SIDE OF THE PAGE FOR MORE INFORMATION ABOUT PSYCHOTHERAPISTS

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

LEGAL CONCERNS:

IS YOUR CHILD 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):

Family HX of: _____

STRENGTHS:

FRIENDSHIPS, COMMUNITY, & SPIRITUALITY (Describe quality, frequency, activities, etc.):

Please add on the other side of the page or on a separate page any other information you would like me to know about you and your situation.

What gives your child the most joy or pleasure in his/her life?

What are his/her main worries and fears?

What are his/her most important hopes or dreams?

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