

Denver Art Therapy & Counseling, LLC

BIOGRAPHICAL INFORMATION-INTAKE FORM

NAME: _____ MALE/FEMALE: ____ DATE: _____
DATE OF BIRTH: _____ AGE: _____
PLACE OF BIRTH _____

Social Security # (for insurance) _____
INSURANCE/ PAYOR SOURCE _____

Is client (check one) Primary Insured ____ or Dependant ____
If Dependent name and DOB of Primary Insured _____

ADDITIONAL PEOPLE LIVING IN THE HOME:

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

OTHER PEOPLE CLOSELY INVOLVED WITH YOU NOT LIVING IN THE HOME:

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

ADDRESS: _____

FOR CONFIDENTIAL/PRIVATE MESSAGES: Phone # _____ E-mail: _____

PERSON & PHONE # TO CALL IN EMERGENCY: _____

REFERRAL SOURCE: _____

HIGHEST GRADE/DEGREE: _____ TYPE OF DEGREE: ____

OCCUPATION (former. if retired): _____

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

ADDITIONAL CONCERNS:

Quality of Sleep (nightmares, difficulty, 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.

Eating Habits (Recent Changes?): _____

Work Difficulties: _____

Difficulties with peers: _____

Sexual Behavior: _____

Poor Self-Esteem: _____

Lying/Stealing: _____

RISK OF HARM: Impulse to hurt self or others? Previous Suicide Attempts?

It is helpful for me to know your expectations so I can select interventions that are appropriately suited to the amount of time we have together. The therapeutic relationship is one of the few relationships where do you have more control as to how long and how often we meet. I believe the end of therapy is just as important as the beginning and strive to have a conscious, successful termination of our relationship. Do you have any expectations about our work together (how long, how frequent, etc.)

FAMILY HX:

CURRENT: Marital status: _____ **Live with someone:** _____ **Name:** _____ **Years:** _

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

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. _____

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.

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: _____

MEDICAL DOCTOR/S (name /phone): _____

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

SPECIFY MEDICATION you are presently taking and for what. PRINT clearly:

ALLERGIES _____

PAST/PRESENT PSYCHOTHERAPY (specify: how long, initial reason for therapy, Ind/Couple/Family, medication, brief description of the relationship and how helpful it was, and how/why it ended):

1. _____

2. _____

PAST/PRESENT DRUG/ALCOHOL USE/ABUSE: (Please indicate when and how much)

LEGAL CONCERNS:

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):

Family HX of: _____

PERSONAL HX:

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

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.

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

STRENGTHS:

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

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?

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