Denver Art Therapy & Counseling, LLC

BIOGRAPHICAL INFORMATION-INTAKE FORM (Children)

NAME OF CHILD: ______________________________ **MALE/FEMALE:** ____
DATE:___________
DATE OF BIRTH: ____________________________________ **AGE:** _______
PLACE OF BIRTH ____

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 CT. NOT LIVING IN THE HOME:

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

CT'S ADDRESS: ____

FOR CONFIDENTIAL/PRIVATE MESSAGES: Phone #_______________**E-mail:** ______________

HIGHEST GRADE: ___________ **SCHOOL:** ____

PERSON & PHONE NO. TO CALL IN EMERGENCY: ____________________________________

REFERRAL SOURCE: ____

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:

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.

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

Enuresis or Encopresis: ____

Eating Habits (Recent Changes?):____

Academic Difficulties: ____

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________

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 it lasts, however, I believe the ending is just as important as the beginning in therapy and strive to have a conscious, successful termination of our relationship. Do you have any expectations regarding this episode of care for your child (how often, how long, should one or both parent's participate, etc) ?

____

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:____

____

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.

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/: ______________________________

____

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 <u>MEDICATION</u> child is presently taking, dosage, reason. <u>PRINT</u> 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. ____

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.

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.):

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?

If child ct, permission to receive candy, stickers during session? ________________

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.