Aerie Art Therapy Services

Natural • Expressive • Safe • Transformative

Intake Form

Name: _____

Date of Birth: _____

Reason for seeking service: _____

Have you ever been diagnosed with any of the following:

☐ ADHD	☐ Reactive Attachment	☐ Sensory Processing Disorder
☐ Anxiety	☐ Hearing Impairment	☐ Heart Disease
☐ Depression	☐ Visual Impairment	☐ Seizures
☐ Bipolar Disorder	☐ Autism Spectrum Disorder	☐ Diabetes
☐ Thyroid Problems		

If yes to any of the above, please provide details such as by who, when, and what treatments you have received:

Family Doctor: _____

Address: _____ Phone: _____

Last medical exam:

Any serious medical issues:

☐ Accident	☐ Eye Problems	☐ Hearing Problems
☐ Hospitalization	☐ Allergies	☐ Meningitis
☐ High fever	☐ Loss of Consciousness	☐ Head Injury
☐ Asthma	☐ Seizures	

Other:

Current medical problems

Medications

Do you have any concerns that have not been listed?

Has the client ever experienced any type of abuse? Explain

Have you been exposed to any other type of trauma?

Has the client ever made statements about self harm, or hurting others?

Has the client ever hurt themselves or others?

Has the client ever experienced serious emotional loss, such as death or physical separation

Are there other stressors in the family or elsewhere?

To your knowledge is there a family history of mental illness or other medical concerns related to your concerns?

Resources

Positive relationships outside of family unit, explain

Hobbies /interests/talents

Favourite Food: _____

Favourite Music: _____

Favourite Place: _____

Other:

Goals

Based on the above information, what issues do you want to see change?

What outcomes are you hoping for? How will you know if progress is being made?