Westchester Creative Arts Therapy, PLLC
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Intake

Contact information:

Name:_____ Date of Birth:_____ Age:_____

Address:_____

Phone numbers: (please circle preferred number)

Cell_____

Home_____

Work_____

Relationship status:_____

Children:_____

Family living in the home:_____

Occupation:_____

Emergency Contact:

Name:_____

Relationship: _____

Cell:_____Home:_____Work:_____

Below is a list of some common concerns. Please mark or circle all of the items below that apply, and feel free to add any others under "Any other concerns or issues." You may add a note or details in the space next to the concerns checked.

_ I have no problem or concern bringing me here
_ Abuse history (and/or current) - physical, sexual, emotional, neglect
_ Abuse of others - physical, sexual, emotional, neglect (of children or elderly)
_ Addictions (alcohol, drug, food, cigarettes, spending, people, other)
_ Aggression, violence
_ Alcohol use
_ Anger, hostility, arguing, irritability
_ Anxiety, nervousness
_ Attention, concentration, distractibility
_ Body image concerns
_ Career concerns, goals, and choices
_ Caregiving for elderly parents or differently-abled family members
_ Children, parenting concerns, child care
_ Codependence - putting other people's needs ahead of yours and not taking care of your own needs
_ Decision making, indecision, mixed feelings, putting off decisions
_ Dependence, separation anxiety
_ Depression, low mood, sadness, crying, inability to feel pleasure, not having fun
_ Divorce, separation
_ Drug use - prescription medications, over-the-counter medications, street drugs
_ Eating problems - overeating, undereating, appetite, binging, purging
_ Family conflict, family constellation issues
_ Fatigue, tiredness, low energy
_ Friendships - quality, quantity
_ Grieving, mourning, deaths, losses, divorce
_ Guilt, shame
_ Headaches, other kinds of pain
_ Health, illness, medical concerns, physical problems
_ Loneliness, isolation
_ Memory problems, foggy thinking
__ Mood swings (may or may not coincide with monthly cycles)
_ Motivation - low motivation or highly driven
_ Nervousness, tension, jumpiness, restlessness
_ Panic or anxiety attacks, fear of panic or anxiety attacks
_ Perfectionism
_ Pessimism
_ Phobias – intense fear around leaving comfortable environment, closed spaces, open spaces, animals, heights, water, bridges, tunnels, specific situations, other
_ Procrastination, work inhibitions, difficulty completing projects
_ Relationship problems - difficulty beginning or remaining in a relationship, conflict, distance/coldness, infidelity/affairs, communication problems, trust
_ Self-abuse
_ Self-centeredness
_ Self-esteem, feelings of low self-worth
_ Self-neglect, poor self-care (exercise, nutrition, hygiene, other)
_ Self-neglect – not taking time for oneself, not taking time for relaxation
_ Sensitivity to rejection, concern with others' opinions
_ Sexual issues, conflicts, desire differences with partner, no/low desire, other

_ Sexual orientation concerns
_ Shyness, sensitivity to criticism
_ Sleep problems - too much, too little, insomnia, nightmares
_ Smoking and tobacco use
_ Social concerns, social anxiety, social inhibitions
_ Spiritual concerns, issues, problems, dissatisfactions
_ Stress, tension, feeling pressured, inadequate stress management
_ Stomach aches
_Suicidal thoughts
_ Unresolved issues/events from the past
_ Weight and diet issues
_ Withdrawal, isolating
_ Work problems, employment, workaholism/overworking, can't keep a job, job stress

Any other concerns or issues: _____
_____
_____
_____
_____
_____

Please look back over the concerns you have checked off and/or added to the check list and prioritize the top three that you would like addressed immediately:

1)_____

2)_____

3)_____

Are you currently taking any medications (including over-the-counter or herbal supplements)?

Have you had psychotherapy or psychiatric medications before? Hospitalization?

Do you have any serious or chronic medical conditions (including past surgeries)?

Are there any other healers, helpers or therapies with which you are involved?

Do you follow a regular awareness practice? (mediation, prayer, affirmation, etc.)

Is there a family history of mental illness, substance abuse or suicide?

Signature:_____

Print Name:_____

Date:_____