Westchester Creative Arts Therapy, PLLC
Mika McLane-Bowes, MPS, LCAT, ATR, CCLS
792 Route 35, #9 Cross River, New York 10518
(845) 581-0140
www.westchestercreativeartstherapy.com
mika@westchestercreativeartstherapy.com

Child Intake

Contact information:

Child's Name:_____ Date of Birth:_____
Age:_____

Parent/ Guardian Names:_____Relationship:____

_____Relationship:_____

Address:_____

Phone numbers: (please circle preferred number)

Cell_____

Home_____

Work_____

Family living in the home:_____

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.

_ Abuse history (and/or current) - physical, sexual, emotional, neglect
_ Abuse of others - physical, sexual, emotional, neglect
_ 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
_ 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
_ 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, 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 orientation concerns
_ Shyness, sensitivity to criticism
_ Sleep problems - too much, too little, insomnia, nightmares
_ Smoking and tobacco use
_ Social concerns, social anxiety, social inhibitions
_ Stress, tension, feeling pressured, inadequate stress management
_ Stomach aches
_Suicidal thoughts
_ Unresolved issues/events from the past
_ Weight and diet issues
_ Withdrawal, isolating

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)_____

Current medications (including over-the-counter or herbal supplements)?

Serious or chronic medical conditions (including past surgeries)?

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

Developmental History:

Were there any issues with delivery or child birth?

Did the client have any issues with motor or speech development? Please describe.

When were these issues first identified?

Please list previous occupational, physical, speech, developmental, creative arts therapies or alternative treatment.

Educational History:

Current School:_____ Grade:_____

At what age did the client start school?

Is the client in a mainstream classroom? Yes No If not, what percentage is mainstreamed?

Has the client skipped or retained grades? Yes No Which?

How are the clients grades?

Have there been identified academic or learning issues?

What are the clients strengths and weaknesses?

If available, we would appreciate access to copies of psychological evaluations, IEPs, school evaluations, hospital or therapy discharge plans or any other professional reports.

Parent Signature:_____

Print Name:_____
Date:_____