Art Therapy Studio Chicago, Ltd.
1579 N Milwaukee Ave Ste 210
Chicago IL 60622
www.art-therapist.org

NPI# 1770915811
EIN# 37-1737453
arttherapystudiochicago@gmail.com

Client Information Today's date: ______________

Name:____

Home street address: ____ Apt: ______________

City: _______________________________ State: ____________________ Zip: _____________________

DOB: __________________ Age: ______ Gender identity__________ Sexual identity _______________

Other Social/Cultural identities___________________Preferred pronouns:_________________________

Cell phone: _____________________________ Home phone: __________________________________

Email: ____

Calls , texts, and emails will be discreet, but please indicate any restrictions:

B. Insurance/Payment information

Will you be using insurance to pay for sessions? Y N

Member's name:____

Member's date of birth:____

Insurance company:____

Member ID:_______________________________ Group #:___________________________________

Dependents: ____

B. Referral/ Inquiry

How did you hear about us?____

Who gave you my name to call? ____

Phone: ____

May I have your permission to thank this person for the referral? Yes No

C. Your medical care:

From whom or where do you get your medical care? ____

Clinic/doctor's name: ___________________________________ Phone: _________________________

E. Your current employer or school:

Employer/School: ____

Phone: ____

F. Emergency contact:____

Phone:______________________________________ Relationship:________________________________

Do I have your permission to contact this person in case of emergency? Y N

FAMILY HISTORY

Where were you primarily raised? ____________________________________ Rural/Urban/Suburban/Multiple moves/Homelessness

Please circle all that apply to your life:

Domestic Violence   Drug abuse in family   Relative/Friend Committed Suicide   Estranged from Parent/Sibling

Child Deceased   Parent Experienced Depression   Military Service   Substance Abuse in Family

Partner Deceased   Victim of Hate Crime   Emotional/Physical/Sexual Abuse   Major Accident

Self/Parent in Jail   Witnessed Family/Community Violence   Chronic Illness/Pain

Separations/Foster Care/Adoption   Serious accidents/Injury   Pregnancy Trauma   Neglect/Abandonment

Please circle the number to rate the following according to the degree to which they are a challenge in your current life (1=little or no concern 6= extreme problem). Also, in the blank, indicate how long each problem has affected you. (*If you have questions about any of these items, please ask)*:			
Depression	1 2 3 4 5 6	Muscle Tension	1 2 3 4 5 6
Extreme Sadness	1 2 3 4 5 6	Headaches	1 2 3 4 5 6
Tiredness	1 2 3 4 5 6	Stomach problems	1 2 3 4 5 6
Feeling hopeless	1 2 3 4 5 6	Gambling	1 2 3 4 5 6
Tearfulness/excessive crying	1 2 3 4 5 6	Memory problems	1 2 3 4 5 6
Extreme energy bursts	1 2 3 4 5 6	Making decisions	1 2 3 4 5 6
Irritability	1 2 3 4 5 6	Confusion/Disorientation	1 2 3 4 5 6
Anger/Rage	1 2 3 4 5 6	Decrease/Increase in appetite	1 2 3 4 5 6
Difficulty concentrating/focusing	1 2 3 4 5 6	Weight gain/loss	1 2 3 4 5 6
Isolating	1 2 3 4 5 6	Dangerous Behavior	1 2 3 4 5 6
Shyness	1 2 3 4 5 6	Concentration problems:	1 2 3 4 5 6
Loneliness	1 2 3 4 5 6	Physical Pain	1 2 3 4 5 6
Feeling fearful/ Excessive worry	1 2 3 4 5 6	Inferiority Feelings	1 2 3 4 5 6
Boredom	1 2 3 4 5 6	Sexual Problems	1 2 3 4 5 6
Insomnia	1 2 3 4 5 6	Physical disability	1 2 3 4 5 6
Nightmares	1 2 3 4 5 6	Alcohol Use # drinks/wk:	1 2 3 4 5 6
Lack of energy/Fatigue	1 2 3 4 5 6	Caffeine # drinks/wk:	1 2 3 4 5 6
Nervousness	1 2 3 4 5 6	Tobacco # packs/wk:	1 2 3 4 5 6

Unhappiness	1 2 3 4 5 6	Other Drug Use type:	1 2 3 4 5 6
Manic Behavior	1 2 3 4 5 6	Sexual abuse/assault	1 2 3 4 5 6
Panic attacks	1 2 3 4 5 6	Acculturation	1 2 3 4 5 6
Sexualized thoughts	1 2 3 4 5 6	Separation/Divorce	1 2 3 4 5 6
Compulsive behavior	1 2 3 4 5 6	Relationship Issue	1 2 3 4 5 6
Obsessive Thoughts	1 2 3 4 5 6	Educational Issue	1 2 3 4 5 6
Binging/Purging	1 2 3 4 5 6	Parenting Issue	1 2 3 4 5 6
Feeling Guilty	1 2 3 4 5 6	Financial Issue	1 2 3 4 5 6
Feeling stressed	1 2 3 4 5 6	Problems at work	1 2 3 4 5 6
Ambition/Perfectionism	1 2 3 4 5 6	Legal Matter	1 2 3 4 5 6
Acting violently or aggressively	1 2 3 4 5 6	Health Care Issue	1 2 3 4 5 6
Thoughts about hurting or killing yourself	1 2 3 4 5 6	Targeted by racism, classism, heterosexism, ableism, and/or other oppression(s)	1 2 3 4 5 6

What you have tried or are you trying now to resolve any of the above challenges:

____

____

____

____

PAST HISTORY

Have you ever received mental health, counseling, therapy, psychiatric or psychological help of any kind? Yes/No

Therapist's Name	Dates Seen	How it was/was not helpful

Have you ever been hospitalized? Yes/No If yes, what happened?

____

____

____

Have you ever received treatment of any kind (including attending AA/NA groups) related to alcohol or other drugs, including prescription? Yes/No If yes, where and

when:____

____

____

YOUR LIFESTYLE AND SOCIAL CONTEXT

Other people living in your home:

Name					
Age/DOB					
Relationship					
Pets :					

What do you do for relaxation and enjoyment?

____

____

Who are the most important people currently in your life?

____

____

What kinds of social/political issues are most important to you?

____

____

Do you have a spiritual belief system/attend a congregation? If so, please explain:

____

____

How do you handle conflict?

____

____

What do you value most in life?

____

____

How many hours each day is the television on in your home? _______________

How many hours each day do you spend on the computer for recreation? ______________

BODY/ MIND HEALTH AND WELLNESS

What kinds of physical activity do you enjoy?

____

How many times a week do you exercise? ________ For how long each time? ________

How many meals do you eat per day? ___________ How many times per week do you sit down with others to eat?

____

How many times per month do you receive any of the following kinds of care: Acupuncture _____________

Massage _____________ Physical Therapy ________ Chiropractic __________ Homeopathic/Naturopathic

____________ Other alternative care ________________

What medications are you currently taking (include vitamins/herbs)?

____

____

What kinds of physical/medical conditions are currently problems for you?

____

____

What kinds of recreational drugs and how many times per week do you use (alcohol, cigarettes, etc)?

____

____

Do you have allergies? Yes/No If yes, to what?

____

In your own words, please describe, in general, what you hope to gain from attending therapy.