Art Therapy Studio Chicago, Ltd.
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Client Information Today's date:_____

Name:_____

Home street address: _____ Apt.:_____

City: _____ State: _____ Zip: _____

DOB: _____ Age: _____

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? oYes oNo

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

G. Please list the names and ages of your family members:

H. Please list any medications and dosages you are currently taking:

I. Please list any hospitalizations (psychological or medical):

J. Please describe any family history of mental illness:

K. What is your relationship status?

L. Please summarize the reason you came to see me today:

Please check any current or past issues that apply to you.

___ Eating Disorders/Body Image
___ Academic Issues
___ Childhood Abuse (Physical, Sexual, Emotional)
___ Stress/Anxiety
___ Phobias (type: _____)
___ Alcohol/Other Drug Use
___ Sexual Assault/Rape
___ Grief and Loss
___ Divorce/Separation
___ Pregnancy Issues
___ Spiritual Concerns
___ Depression
___ Impulsivity
___ Sexual Identity Issues
___ Relationship Concerns
___ Family Distress
___ Financial Stress
___ Work Related Issues

Other:_____

Please feel free to elaborate on any issues:

If you are currently experiencing any of the following symptoms, please rate them using the number key below.

Never 0 ***Seldom 1*** ***Often 2*** ***Always 3***

___ Difficulty concentrating

___ Crying

___ Missing work/class

___ Feeling helpless

___ Feeling uptight/tense

___ Restrictive eating

___ Worrying

___ Feeling hopeless

___ Feeling afraid

___ Lying to others

___ Feeling out of control

___ Feelings of self-doubt

___ Self- Injury

___ Loneliness

___ Nervousness around others

___Memory loss or blackout

___ Difficulty sleeping

___ Stealing

___ Anger

___ Eating binges

___ Skin or hair picking

___ Drinking heavily

___ Other drug use

___ Feelings of guilt

___ Withdrawing socially

___ Sexual preoccupation/obsessions

___ Physical symptoms (i.e. headaches, digestive)

List: _____

____ Suicidal thoughts

____ Homicidal thoughts

Other:

For office use only

1.

2.

3.