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Licensed Professional Art Therapist
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502-930-5057

CONFIDENTIAL CLIENT INTAKE FORM

Please fill out this form and bring it to your first session. Please note that the information you provide here is protected as confidential.

Client Information:

Name: ____
Last First Middle Initial

Name of Parent or Guardian (if under 18 years):

____
Last First Middle Initial

Birth Date: _____/_____/______ Age:________ Gender: ____Male_____Female

Marital Status:
____Single ___DomesticPartnership ____Married ___Separated ___Divorced ___Widowed

Please list any children/age:____

Who lives in the home (names, ages, relationship)_____________________________

____

Address:____
(Street and Number)

____
(City) (State) (Zip Code)

Home Phone: ( ) ________________ Cell Phone ( )_________________________

May I leave a message? Y/N   Prefer Messages to be left: _____Home   _____Cell

Text Messages: Y/N (appointment reminders, etc)

Email:_________________________________ May I email you? ______Y   _________N
**Please note Email correspondence is not considered to be a confidential medium of communication.*

Occupation/Employer:____

Emergency Contact/Name:_____________________________Phone(____)____________________

Relationship to you:______________________________Address:____________________________

Referral Sources (how did you hear of my services?)_________________________________

Please briefly describe the problem/issue that brings you to counseling/duration:__________________
____

What motivated you to seek assistance at this time?____
____

Have you been in therapy before?   Yes   No if yes, please describe reason, duration, outcome and therapist.____
____

Please list any previous medical problems, treatment, and outcomes.___________________________
____

Please list any current medical problems, treatment, and outcomes.____________________________
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Please list any previous psychiatric/psychological problems, treatment, and outcomes:
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____

Have you ever been hospitalized? Yes No If yes, please describe reason, location, duration:
____

Please list any medications you are currently taking:____
____

Please list any medications you have previously taken:______________________________________
____

Physicians name:_____________________________ Physicians phone:_______________________

Psychiatrists name:__________________________ Psychiatrists phone:_______________________

Would you like your other health care provider(s), teachers, etc to be informed of your progress in Art Therapy to better coordinate your treatment? ________Yes ___________No

If yes, please list all those that therapist has permission to contact about your case. Please add phone number and/or contact information for each person listed below.

Client Signature:_____________________________ Client Name: (print)_________________________
Date____

Have you used drugs or alcohol?___Yes____No. If yes, please describe the substance and frequency of use.____

If applicable, please describe any previous or current treatment for chemical dependancy.___________

Family history of mental illness, hyperactivity, mental/developmental delays, chemical dependency, suicide, major medical problems, and/or trauma____

Please list your strengths, including those people in your support system._________________________

Do you currently see any obstacles that would be limiting to your progress in therapy sessions?______

Please list any significant (positive or negative) life changes or stressful events you have experienced recently.____

Please describe your spiritual/religious orientation.____
What would you like to accomplish during your time in art therapy?______________________________

Is there anything else I you'd like me to know about you and or situation(s) bringing you to therapy?

Active Credit Card to be kept on file: #____
Name on Card:____
Expiration date:_____________________ **Code:**_______________________________________

Form(s) Completed By:____

Relationship to client:____

By signing, I am agreeing that the above information, provided by client and/or guardian is accurate and honest.

____ ______________________
(Signature of client/guardian) (Date)

Below Goals to be completed at first session with therapist.

Goals, Dx, and Tx Plan.

____
____
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Art Therapy Client Service Agreement

Consent Form

This form outlines the Art Therapy services provided, and the expectations of the therapist and the client. It is intended to provide you with the information necessary to feel safe and supported in your decision to do Art Therapy.

CONFIDENTIALITY
Any information about you and/or your artwork is held with utmost confidentiality and can only be released by either your written or signed consent by court order.

CONFIDENTIALITY EXCEPTIONS
1. When you may be a danger to yourself or others I am obligated to keep you safe.
2. When there is suspicion of disclosure of child abuse I am obligated to report.
3. When records are subpoenaed by court order
4. When you give permission to consult with other individuals/professionals as required.

APPOINTMENTS
- Art Therapy appointments are scheduled with the art therapist.
- If you are unable to attend a session, it is your responsibility to inform the art therapist in advance so that time can be made available to others.
- You will be responsible to pay for any appointment that has been missed or cancelled without 24 hours advance notice at the regular rate unless the art therapist is able to fill the time.
- Please note that if you wake the morning of your appointment and are ill accommodations can be made for that circumstance, but cancellations that morning is required, if appointments is just missed the client will be charged the full service fee.

PAYMENT
- The standard art therapy session of 50min-1 hour is available at $75.
- 90 minute sessions are billed at the rate of $125.
- There will be a $30 charge for all returned checks.
- Failure to pay for services may result in the termination of the therapeutic relationship.
- Payments can made through cash, check, or credit card at the time of service
- Invoices can be e-mailed or handed to client directly at client’s request.
- Should you default on your payments, your signature below indicates that you will be billed for reasonable attorney/court fees should your account be turned over to collections.
- Outstanding balances will be subject to a 5.0% monthly charge.

TECHNICAL AGREEMENT
- Client can contact the art therapist by email to confirm or change appointment or basic information. Clinical questions will not be answered over email and will be deferred to the next session.

GENERAL
In your art therapy sessions you will be asked to outline your needs, goals, and the way you would like to improve your emotional and mental health. This work may bring up unpleasant or troubling feelings and memories. If this is your experience please do not hesitate to address is with the art therapist so she can further support you. Continuing art therapy sessions is encouraged, as they will help you work through these difficult feelings.

Art Therapist Responsibilities

- Be prepared and on time for each session
- Provide safe and supportive environment for the client
- Keep all information and artwork confidential (unless noted in Confidentiality Exceptions above)

Client Responsibilities

- Keep appointments by showing up on time and paying the fee
- Be open and trust the process of art therapy
- Be honest.

Client AGREEMENT

I__________________________________ have been informed of the above conditions and accept the terms of service for art therapy. I have read, understand and agree with the above. I acknowledge that I have had the opportunity to ask questions, understand the information, and accept the guidelines/ expectations that were presented.

Name (Please print)____

CLIENT SIGNATURE____DATE_______________
(unless under the age of 18-parent signature required)

PHONE #_______________________________

EMAIL:_________________________________

THERAPIST SIGNATURE____________________________________DATE________________