NAZARETH COLLEGE

York Wellness & Rehabilitation Institute
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York
WELLNESS & REHABILITATION
Institute

Art Therapy Intake Form

Today's Date: _____ Record # (WRI USE): _____

I. <u>Identifying Information</u>:

Preferred name: _____

Legal name: _____

Date of Birth: _____ Age: _____

Gender: ☐Female ☐Male ☐AMAB ☐AFAB ☐Transgender

Additional Information: _____

What pronouns would you like staff to use? _____

Primary language: _____ Secondary language: _____

II. <u>Contact Information</u>:

Address: (Street) _____

(City/Town) _____ (Zip) _____

Preferred Phone: _____ Alternate Phone: _____

May we leave a message on your (caregivers) preferred phone? ☐Yes ☐No

May we communicate with you via email? ☐Yes ☐No

Email: _____

Primary caregiver (if appropriate): _____

Relationship: _____ Phone #: _____

Person to call In case of Emergency, call: _____

Relationship: _____ Phone #: _____

Transportation to Clinic: ☐I will drive myself ☐Provided by: _____

Primary Care Physician: _____ Phone #: _____

III. <u>Nature of Services Requested</u>:

<u>Please</u> describe the ***primary reasons*** why art therapy is being sought:

What are your current concerns/needs?

What are your strengths?

What are your goals for art therapy?

Beginning Art Therapy

Have you ever been in an art therapy session before? Yes [ ] No [ ] If so, where and when?
Previous Art Therapist Name: _____

Town/City_____

Are you currently under the care of any other counselor, psychologist or psychotherapist?
Name:

_____

_____

Referring person: _____ Relationship: _____

Have you ever received services at a Nazareth Clinic? ☐Yes ☐No

If so, which clinic(s), and when? _____

IV. <u>Other services received</u>: Please note any services/therapies that you currently receive or have recently received outside of the Nazareth clinics and where.

Services/therapy	Location	Approximate dates

Culture and Community

What is your native language? _____

Is there anything related to your culture that I should know that will help make you more comfortable?

_____

_____

_____

Do you have supports in the community?_____

_____

_____

Do you have any hobbies, arts or activities that you enjoy participating in, now or in the past?

_____

_____

_____

Medical History:

Current problem(s) Please be as detailed as possible regarding any relevant information.

_____

_____

_____

_____

_____
_____
_____

Please list all medications that you are presently taking:
_____
_____
_____
_____
_____
* Please notify the clinic of any changes in medications or medical status.

Hospital of choice:
_____

Are you currently under the care of any other medical specialist?
Name_____

_____Town.City_____

Reason for seeing _____

Do you have any problems with your vision? Yes [ ] No [ ]
If yes, describe the vision difficulty.
_____
_____
_____

Do you wear glasses or contacts? Yes [ ] No [ ]

Do you have a hearing loss? Yes [ ] No [ ] Do you wear a hearing aid? Yes [ ] No [ ]

Please describe hearing difficulty.
_____
_____
_____

IV. Other Pertinent Information:

Are there any answers that you think you may find, or issues that you may work through, using art making materials? Please provide any additional information that might be helpful in understanding your needs.
_____
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Additional Comments:

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Person completing this form: ☐Self ☐Other: _____

Relationship: _____

Signature: _____

☐I understand that checking this box constitutes a legal signature. Date: _____