Child and Adolescent New Client Questionnaire for Counseling and Art Therapy

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4445 NE Fremont St., Portland, OR 97213 • www.creativecounselingpdx.com

New Client Name _____ **Date** _____

Parent/Guardian(s) and their child/teen are invited to complete this together as appropriate. If you see a section you have questions about or don't want to answer, feel free to skip it.

Person(s) completing this form: _____

What made you decide to try art therapy or counseling at this time?

_____

_____

What are you hoping art therapy or counseling will help you with?

_____

_____

Are you having suicidal thoughts or any other urgent concern right now?

_____

_____

Parent/Guardian Contact Information

My biological parents are: ___Married ___Separated ___Divorced ___Deceased ___Other

Custody (if applicable)

Legal custody is ___joint ___sole Name(s) _____

Physical custody is ___joint ___sole Name(s) _____

Address #1 _____

Phone # 1 _____ OK to leave detailed voicemail? _____

Address #2 (if applicable) _____

Phone # 2 _____ OK to leave detailed voicemail? _____

Email _____ OK to email about appointments? _____

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Client Information

Birth Date _____ Gender Identity _____ Sexual Orientation _____

Ethnicity/National Origin _____

What cultural, religious or other traditions are important to you?

_____

School

What school do you attend_____

What grade are you in_____

Is your school work ___Too hard ___About right ___Too easy

In class work are you ___ Ahead in class ___ Keeping up ___ Falling behind

Do you have an IEP (Individualized Education Plan)? _____ If yes, for_____

_____

School Counselor (if involved) Name_____ Phone _____

Relationships

Who lives with you or is a significant part of your life?

Name	Age	Relationship to you
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I have ___One best friend ___Many friends ___No one I really trust ___I wish I had more friends

Any problems with friends or others at school or in your life? _____

_____

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History

Please list and describe previous experiences with counseling, therapy or psychiatric hospitalizations

_____

_____

_____

Is there a history of mental illness in your family? If so please describe _____

_____

_____

Has anyone in your family died by suicide? _____ If so, when and how? _____

_____

_____

Please list any major medical illness, injury or physical or emotional trauma you have experienced

_____

_____

_____

_____

Do you have any current medical issues? If so please describe _____

_____

_____

Are you taking any medications? If so please describe _____

_____

_____

Do you have any friends who drank beer, wine, or any alcoholic drink in the past year? _____

Do you have any friends who have smoked or used any type of drug in the past year? _____

Have you ever tried alcohol or any kind of drug (not a prescription)? _____

If yes, what have you tried_____

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Resources

What are some things going well for you now?

_____

_____

What are some things about you that you feel good about?

_____

_____

What are the activities you enjoy – how often do you do them?

_____

_____

What are the people, places and things that help you feel supported?

_____

_____

Is there any other significant information about your life and experience that you'd like me to know?

_____

_____

_____

_____

Thank you for taking the time to complete this questionnaire!