Art Therapy Intake Assessment

Personal Information

Client Name

Date of Birth

Address

Phone Number

Email

Emergency Contact

Referral Information

Referral Source

Reason for Referral

Presenting Concerns

Presenting Concerns

Goals for Art Therapy

Medical & Mental Health History

Relevant Medical/Psychiatric History

Current Medications

Other Treatments/Support

Previous Art Therapy Experience

Previous Experience with Art or Art Therapy

Preferred Art Materials/Methods

Additional Information

Personal Strengths

Other Notes