

THE URBAN ART BARN:

AN ART PSYCHOTHERAPY PRACTICE

www.theurbanartbarn.com

Erin Lamon, LMFT
Licensed Marriage & Family Therapist (LF 60473714)
Art Therapist

206.659.8156
theurbanartbarn@gmail.com

3400 Harbor Ave SW # 303
Seattle WA 98126

INDIVIDUAL / FAMILY INTAKE

Please be aware this information is considered privileged thus it is kept confidential.

Name: _____ Age: _____ DOB: ___/___/___ Gender: _____

Caregiver (if applicable): _____

Phone: _____ (cell) _____ (home) _____ (work)

Which is a primary number? _____ Can I leave a voicemail? Y / N

Email: _____

Address: _____

Emergency Contact: _____ Phone: _____

Work or Occupation: _____

Referral Source: _____

With whom do you live? _____

Have you received any mental health services (therapy or psychiatric services)? Y / N

Please elaborate (where and when): _____

Are you currently taking any medication (prescription medications, birth control pills, vitamins, herbs or other supplements)? Y / N

Please elaborate (what and how long): _____

Have you ever been prescribed psychiatric medication? Y / N

Please elaborate (what and when): _____

How would you rate your current physical health?

Poor / Unsatisfactory / Satisfactory / Good / Excellent

Are you currently experiencing any specific health problems? Y / N

Please elaborate (what and how long): _____

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Are you currently experiencing any chronic pain? Y / N

Are you currently using an alternative medicine practices? _____

How would you rate your current sleeping habits?

Poor / Unsatisfactory / Satisfactory / Good / Excellent

Any difficulties with your appetite or eating patterns? Y / N

Are you currently experiencing overwhelming sadness, grief or depression? Y / N

Please elaborate (what and how long): _____

Are you currently experiencing anxiety, panic attacks or have any phobias? Y / N

Please elaborate (what and how long): _____

Have you ever experience thoughts of harming yourself or others? Y / N

How many caffeinated beverages you drink per day? _____

How many cigarettes do you smoke each day? _____

How often do you drink alcohol?

Daily / Weekly / Monthly / Infrequently / Never

How often do you engage in recreational drug use?

Daily / Weekly / Monthly / Infrequently / Never

Do you use drugs and/or alcohol to do any of the following?

Manage Stress Y / N

Relax Y / N

Change Mood Y / N

Sleep or Control Appetite Y / N

Are you currently in a romantic relationship? Y / N

Please elaborate (what and how long): _____

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Have you ever experienced any of the following?

Physical Abuse Y / N
Emotional Abuse Y / N
Sexual Abuse Y / N
Sexual Assault Y / N

Please name several people who you feel are supportive: _____

Do you have family members who are supportive? _____

Have you had any significant life changes or stressful events recently? Y / N

Please elaborate (what and when): _____

Are you working? Y / N

What is your current employment? _____

Do you enjoy your job? Y / N Is there anything stressful about you current job? Y / N

Do you currently have insurance? Y / N

Please elaborate (what and where): _____

Do you consider yourself to be spiritual or religious? Y / N

What is your faith or belief system? _____

What are some of your strengths? _____

What are some of your weaknesses? _____

How might therapy be most helpful to you? _____

