ita
institute for therapy through the arts

Please mail or fax to:
2130 Green Bay Rd, Evanston, IL 60201
Phone: 847-425-9708 Fax: 847-448-8337

Client Registration Packet - Adult: Today's Date: _____

Client Name _____ Nickname _____ Date of Birth _____ /_____ /_____

Gender: _____ (examples: man, woman, nonbinary) Pronouns: _____ (examples: she, they, he) Sexual orientation _____

Address _____ City _____ State _____ Zip _____

Home Phone (_____) _____ Work Phone (_____) _____ Cell Phone (_____) _____

Can we leave a message? Home ☐ Y ☐ N Work ☐ Y ☐ N Cell ☐ Y ☐ N

Email _____ Fax (_____) _____ Marital Status _____

Referral Information

Referred by _____ Referral Contact Phone (_____) _____

Referral E-mail _____ May ITA Contact the Referral? ☐ Y ☐ N

I, _____, grant my permission for ITA to contact my referral source, if possible, to acknowledge and thank them for the their referral. I understand I will not be identified in any way through this contact. _____(initial here)

Billing Information

Billing Name _____

Relationship to Client _____

Address (if different than above) _____

City _____ State _____ Zip _____ Primary Phone (___)_____

Payment Type: ☐ BCBSIL ☐ Other Insurance ☐ Self Pay ☐ Financial Aid

Insurance Information

Name of Policy Holder _____ Insurance Company _____

Policy Number _____ Group Number _____

Emergency Information

Contact Name _____

Relationship to Client _____ Primary Phone (___)_____

Primary Care Physician _____ Phone (___)_____

Psychiatrist/Therapist _____ Phone (___)_____

Guardianship Information

Power of Attorney _____ Relationship _____

Power of Finance _____ Relationship _____

Presenting Issue

Please describe the reasons you are seeking services: _____

_____

_____

_____

_____

_____

Please check the symptoms you have experienced recently:

Symptom	2 Weeks	6 Months	Symptom	2 Weeks	6 Months
Anxiety	☐	☐	Weight Loss	☐	☐
Excessive Worry	☐	☐	Weight Gain	☐	☐
Restlessness	☐	☐	Insomnia	☐	☐
Concentration Issues	☐	☐	Hypersomnia	☐	☐
Irritability	☐	☐	Fatigue	☐	☐
Flashbacks	☐	☐	Excessive Guilt	☐	☐
Intrusive Thoughts	☐	☐	Worthlessness	☐	☐
Nightmares	☐	☐	Suicidal Thoughts	☐	☐
Difficulty Falling Asleep	☐	☐	Homicidal Thoughts	☐	☐
Difficulty Staying Asleep	☐	☐	Distractibility	☐	☐
Hypervigilance	☐	☐	Unrestrained Purchasing	☐	☐
Anger Outbursts	☐	☐	Impulsive Sexual Behaviors	☐	☐
Lack of Interest in Activities	☐	☐	Mood Swings	☐	☐
Social Isolation	☐	☐	Delusions	☐	☐
Social Interaction Problems	☐	☐	Hallucinations	☐	☐
Detachment	☐	☐	Memory Problems	☐	☐
Heart Palpitations	☐	☐	Apraxia	☐	☐
Sweaty Palms	☐	☐	Communication Issues	☐	☐
Difficulty Breathing	☐	☐	Fine Motor Issues	☐	☐
Panic Attacks	☐	☐	Gross Motor Issues	☐	☐
Repetitive Behaviors	☐	☐	Sensory Processing Issues	☐	☐
Obsessive Thoughts	☐	☐	Daily Tasks of Living Issues	☐	☐
Depressed Mood	☐	☐	Other_____		

Have you received a diagnosis for these symptoms? _____

_____ Date_____

Was an evaluation conducted? ☐ Y ☐ N

Location of Evaluation _____

Diagnosing Clinician _____

Significant life changes in past 6 months: ☐Move ☐ Death among family/friends ☐ Birth in family
☐ Relationship change ☐School change ☐Job Change ☐ Other

Please describe significant life changes: _____

_____

Medical History

Please list any current medications: Prescribing Clinician _____

_____ Dosage _____ Date Prescribed _____

_____ Dosage _____ Date Prescribed _____

_____ Dosage _____ Date Prescribed_____

_____ Dosage _____ Date Prescribed_____

Please list any allergies: _____

_____

Please check any of the following that apply to you and your medical history.

☐ Arthritis
☐ Asthma
☐ Brain Injury
☐ Cancer
☐ COPD
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Fainting
☐ Headaches
☐ Glaucoma
☐ Hearing Impairment
☐ Heart Condition
☐ Herpes
☐ High Blood Pressure
☐ High Cholesterol
☐ Hypoglycemia
☐ Kidney Disease
☐ Low Blood Pressure
☐ Chest Pain/Pressure
☐ Seizures
☐ Shortness of Breath
☐ Stomach, Liver or Intestinal Problems
☐ Stroke
☐ Tuberculosis
☐ Thyroid Problems
☐ Visual Impairment
☐ Other _____
_____
_____

Please list any past hospitalizations, including reason, date, and hospital. _____

_____

_____

_____

Have you been psychiatrically hospitalized? ☐ Y ☐ N

_____ Dates: _____

_____ Dates: _____

_____ Dates: _____

_____ Dates: _____

Please list previous counseling, therapy (speech, physical, occupational), creative arts therapies, psychiatric or alternative therapies.

Treatment Type	Dates of Treatment	Outcome
_____	_____	☐ Poor ☐ Fair ☐Good ☐ Excellent
_____	_____	☐ Poor ☐ Fair ☐Good ☐ Excellent
_____	_____	☐ Poor ☐ Fair ☐Good ☐ Excellent
_____	_____	☐ Poor ☐ Fair ☐Good ☐ Excellent

Activities of Daily Living

Task	Unable	Total dependence	Mostly dependent	Requires assistance sometimes	Needs supervision	Uses devices	Independent
Bathing	☐	☐	☐	☐	☐	☐	☐
Dressing	☐	☐	☐	☐	☐	☐	☐
Mobility/transfer in bed	☐	☐	☐	☐	☐	☐	☐
Toilet Use	☐	☐	☐	☐	☐	☐	☐
Eating	☐	☐	☐	☐	☐	☐	☐

Instrumental Activities of Daily Living

Task	Unable	Total dependence	Mostly dependent	Requires assistance sometimes	Needs supervision	Uses devices	Independent
Light housekeeping	☐	☐	☐	☐	☐	☐	☐
Heavy housework	☐	☐	☐	☐	☐	☐	☐
Shopping	☐	☐	☐	☐	☐	☐	☐
Laundry	☐	☐	☐	☐	☐	☐	☐
Driving	☐	☐	☐	☐	☐	☐	☐
Preparing meals	☐	☐	☐	☐	☐	☐	☐
Managing money	☐	☐	☐	☐	☐	☐	☐
Using telephone	☐	☐	☐	☐	☐	☐	☐

Social History

Are you currently in a significant relationship? ☐ Y ☐ N With whom _____

Do you feel satisfied in your current relationship? ☐ Y ☐ N Describe your relationship _____

_____

Please list any other notable or significant previous relationships:

_____

_____

Please list any children or dependents.

1. _____ Age _____ Live with you? ☐Y ☐ N If not, last seen _____
2. _____ Age _____ Live with you? ☐ Y ☐ N If not, last seen _____
3. _____ Age _____ Live with you? ☐ Y ☐ N If not, last seen _____
4. _____ Age _____ Live with you? ☐ Y ☐ N If not, last seen _____
5. _____ Age _____ Live with you? ☐ Y ☐ N If not, last seen _____

Who else lives in the home? _____

_____

_____

Are you satisfied with your living arrangement? ☐ Y ☐ N Describe_____

_____

Describe the nature and frequency of your social interaction: _____

_____

_____

Do you engage in any personal hobbies, leisure, or physical activities: _____

_____

_____

Work History

Are you currently employed? ☐ Y ☐ N Occupation:_____

Where?_____

Reasons for unemployment: _____

Are you satisfied with your current job? ☐ Y ☐ N Describe:_____

_____

Childhood Family Composition

Parent 1 _____

Gender: _____ Pronouns: _____

DOB _____/_____/_____ Deceased ☐ Y ☐ N

Marital Status _____

Education _____

Occupation _____

Health ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Religious Affiliation _____

Your Relationship

☐ Healthy ☐ Loving ☐ Strained ☐ Abusive

Present during Childhood ☐ Y ☐N Ages_____

Military ☐ Y ☐ N Division _____

Deployed ☐ Y ☐ N Length _____

Criminal Record ☐ Y ☐ N

Incarcerated ☐ Y ☐ N

Parent 2 _____

Gender: _____ Pronouns: _____

DOB _____/_____/_____ Deceased ☐ Y ☐ N

Marital Status _____

Education _____

Occupation _____

Health ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Religious Affiliation _____

Your Relationship

☐ Healthy ☐ Loving ☐ Strained ☐ Abusive

Present during Childhood ☐ Y ☐N Ages_____

Military ☐ Y ☐ N Division _____

Deployed ☐ Y ☐ N Length _____

Criminal Record ☐ Y ☐ N

Incarcerated ☐ Y ☐N

Siblings

1. _____Age _____Relationship? ☐ Healthy ☐ Loving ☐ Strained ☐ Abusive
2. _____Age _____Relationship? ☐ Healthy ☐ Loving ☐ Strained ☐ Abusive
3. _____Age _____Relationship? ☐ Healthy ☐ Loving ☐ Strained ☐ Abusive
4. _____Age _____Relationship? ☐ Healthy ☐ Loving ☐ Strained ☐ Abusive

Additional Family Information

Were you adopted: ☐ Y ☐ N Age: _____ Type: ☐ Domestic ☐ International ☐ Kinship ☐ Foster

Additional parental figures: _____

History of divorce in family: _____

Development and Education History

At what age did you start school? _____ Did you skip or retain grades? ☐ Y ☐ N Which? _____

How were your grades? ☐ Poor ☐ Below Average ☐ Average ☐ Above Average ☐ Excellent

Did you have any identified academic or learning issues? _____

_____

Did you have any special communication devices? _____

What were your strengths and weaknesses? _____

_____

_____

What is your highest level of education attained? ☐ High School ☐ GED ☐ Bachelors ☐ Masters ☐ Doctorate

Did you have peers/friends? ☐ Y ☐ N Were they? ☐ Younger ☐ Older ☐ Same

Did you experience bullying? ☐ Y ☐ N Did someone intervene? ☐ Y ☐ N

Trauma History

Have you witnessed or experienced a traumatic experience? ☐ Y ☐ N

Please check the events that you have experienced or witnessed.

☐ Natural Disaster
☐ Serious Illness/Injury
☐ Major Accident
☐ Parental Neglect
☐ Interpersonal Control
☐ Financial Exploitation
☐ Physical Abuse
☐ Sexual Abuse
☐ Sexual Assault
☐ Assault/Robbery
☐ Prejudice/Racism
☐ War
☐ Community Violence
☐ Other _____

What age did you experience or witness this event? _____

Have you received therapy or counseling for this event? ☐ Y ☐ N Describe _____

_____

Legal History

Are you currently involved in the legal system? ☐ Y ☐ N In what way? _____

Please check any that apply to your history.

☐ Truancy
☐ Arrests
☐ Incarcerations
☐ Probation
☐ Parole
☐ Conditional Release
☐ Court Ordered Treatment
☐ Juvenile Detention

Substance Use History

Please mark the substances you have used:

Substance	Frequency			Ages	Last Used
☐ Alcohol	☐ Daily	☐ Monthly	☐ Socially		
☐ Marijuana	☐ Daily	☐ Monthly	☐ Socially		
☐ Cocaine	☐ Daily	☐ Monthly	☐ Socially		
☐ Heroin	☐ Daily	☐ Monthly	☐ Socially		
☐ Barbiturates	☐ Daily	☐ Monthly	☐ Socially		
☐ Valium/Xanax	☐ Daily	☐ Monthly	☐ Socially		
☐ PCP	☐ Daily	☐ Monthly	☐ Socially		
☐ LSD/Mushrooms	☐ Daily	☐ Monthly	☐ Socially		
☐ Inhalants	☐ Daily	☐ Monthly	☐ Socially		
☐ Pain Medication	☐ Daily	☐ Monthly	☐ Socially		
☐ Sleep Aid	☐ Daily	☐ Monthly	☐ Socially		
☐ Stimulants	☐ Daily	☐ Monthly	☐ Socially		
☐ Cigarettes	☐ Daily	☐ Monthly	☐ Socially		
☐ Caffeine	☐ Daily	☐ Monthly	☐ Socially		
☐ Other _____	☐ Daily	☐ Monthly	☐ Socially		

Have you been disciplined at work, school or by the court for your substance use? ☐ Y ☐ N

Have you participated in a substance abuse program? ☐ Y ☐ N Dates _____

Do you participate in a 12-step substance abuse program? ☐ Y ☐ N Frequency _____

Military History

Have you served in the armed forces? ☐ Y ☐ N Which division? _____

Dates of service: _____ Did you enlist? ☐ Y ☐ N Were you drafted? ☐ Y ☐ N

Have you been deployed? ☐ Y ☐ N Dates_____ Where? _____

Did you experience combat? ☐ Y ☐ N Have you received services at the VA? ☐ Y ☐ N

Any injuries in the service? _____

Relevant Cultural and Personal Information

Race/Ethnicity: ☐ White ☐ African American or Black ☐ Latinx ☐ Asian ☐ Middle Eastern/North African ☐ Pacific Islander ☐ American Indian/Native American ☐ Bicultural/Biracial

Do you identify with a cultural, national, racial, religious, spiritual or social group? ☐ Y ☐N

Please describe your affiliation: _____

_____

Is there anything you would like us to know about your cultural identification? _____

_____

_____

Do you have any special needs or accommodations?

☐ Non-verbal or Adaptive Communication

☐ Uses walker/wheelchair/cane

(which? _____)

☐ Limited motor function

☐ Other _____

Goals of Therapy

Type of therapy preference: ☐ Individual ☐ Family ☐ Couples ☐ Group ☐ Neurological ☐ Assessment

Past experiences with the creative arts (art, music, drama, dance, other)? _____

_____

Please indicate the goals you have for treatment at this time?

☐ Symptom Reduction
☐ Increased Coping Skills
☐ Increased Self Care
☐ Improved Social Skills
☐ Improved Communication skills
☐ Improved Social Relationship
☐ Improved Romantic Relationships
☐ Improved Family Relationships
☐ Increased Physical Skills
☐ Increased Cognitive Skills
☐ Maintain Cognitive Skills
☐ Maintain Physical Skills
☐ Sensory Integration/Processing
☐ Processing Traumatic Events
☐ Decreased Substance Use/Triggers
☐ Increased Creative and Artistic Expression
☐ Increased Personal Insight
☐ Improved Quality of Life
☐ Complete Court Ordered Treatment

Please list any additional goals _____

_____

If available, we would appreciate access to copies of psychological evaluations, discharge plans, individual family health care plans, individual education plans, or any other professional reports. We will be happy to make photocopies for you.

Print Name _____

Signature_____Date_____

Relationship to Client_____

_____

Intake Clinician's Signature Date

Mental Status Exam – Completed by Intake Clinician

Attitude

☐ Cooperative	☐ Uncooperative	☐ Cautious	☐ Passive	☐ Dramatic
☐ Manipulative	☐ Angry	☐ Domineering	☐ Evasive	☐ Overly Compliant

Appearance	Age	Grooming	Orientation
☐ Well Nourished	☐ Appears Stated	☐ Neat	☐ Person
☐ Malnourished	☐ Appears Younger	☐ Unkempt	☐ Place
☐ Overweight	☐ Appears Older	☐Bizarre	☐ Time
☐ Emaciated			

Behavior

☐ Relaxed	☐ Restless	☐ Agitated	☐ Unusual Gait
☐ Tremors	☐ Tics	☐ Slumping	☐ Rigid

Memory

☐ Intact	☐ Impaired Remote Memory	☐Impaired Recent Memory	☐ Impaired Immediate Recall

Mood/Affect

☐ Normal	☐ Labile	☐ Elated	☐ Sad	☐ Depressed
☐ Restricted	☐ Inappropriate	☐ Suspicious	☐ Laughing	☐ Frightened
☐ Flat	☐ Frustrated	☐ Anxious	☐ Fearful	☐ Anger

Speech

☐ Unremarkable	☐ Excessive	☐ Slow	☐ Incoherent
☐ Loud	☐ Soft	☐ Stammering	

Insight

☐ Good	☐ Fair	☐ No Insight	☐ Denial

Thought Process

☐ No Abnormalities	☐ Word Salad	☐ Circumstantiality	☐ Perseveration
☐ Tangentiality	☐ Echolalia	☐ Difficulty Concentrating	☐ Incoherent
☐ Flight of Ideas	☐ Loose Associations		☐ Neologism

Ideation

☐ Suicidal	☐ Thoughts	☐ Plan	☐ Intent	☐ Past	Description: _____
☐ Homicidal	☐ Thoughts	☐ Plan	☐ Intent	☐Past	Description: _____
☐ Self-Harm	☐ Thoughts	☐ Plan	☐ Intent	☐ Past	Description: _____

Hallucination/Delusions

☐ None	☐ Visual	☐ Olfactory	☐ Persecution	☐ Somatic
☐ Auditory	☐ Tactile	☐ Influence	☐ Grandeur	☐ Reference

Judgment

☐ Intact	☐ Impaired