KidSense Therapy Group
209 Cherry Street
Milford, CT 06460
(203) 874-5437

Art Therapy Evaluation Form

Child's Name:

_____
(Last) (First) (Middle Initial)
Name of parent/guardian (if under 18 years):

_____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female

Please list any sibling/age:

_____

_____

Address:
(Street and Number)
_____

_____
(City) (State) (Zip)

Home Phone: _____ May we leave a message? □Yes □No

Cell: _____ May we leave a message? □Yes □No

Work Phone: _____ May we leave a message? □Yes □No

E-mail: _____May we email you? □Yes □No
*Please note: Email correspondence is not considered to be a confidential medium of communication.
Referred by (if any):

_____

Please describe what concerns you have regarding your child:
_____
_____
_____
_____

How long has the problem existed? _____
What attempts have been made to resolve the difficulties?

_____

Has your child previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
□ No
□ Yes, previous therapist/practitioner:

_____

Is your currently taking any prescription medication?
□ Yes
□ No
Please list:

_____

_____

Has your ever been prescribed psychiatric medication?
□ Yes
□ No
Please list and provide dates:

_____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION
1. How would your child's rate your current physical health? (please circle)
Poor Unsatisfactory Satisfactory Good Very good
Please list any specific health problems your child is currently experiencing:

_____

2. How would you rate your child's current sleeping habits? (Please circle)
Poor Unsatisfactory Satisfactory Good Very good
Please list any specific sleep problems you are currently experiencing:

_____

3. How many times per week does your child generally socialize? _____

What types of socializing do they participate in:

_____?

4. Please list any difficulties you experience with your appetite or eating patterns.

_____

_____

5. Is your currently experiencing overwhelming sadness, grief or depression?
□ No
□ Yes

If yes, for approximately how long? _____
6. Is your child currently experiencing anxiety, panic attacks or have any phobias?
□ No
□ Yes
If yes, when did they begin experiencing this? _____

FAMILY MENTAL HEALTH HISTORY:
In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).
Please Circle List Family Member
Alcohol/Substance Abuse yes/no
Anxiety yes/no
Depression yes/no
Domestic Violence yes/no
Eating Disorders yes/no
Obesity yes/no
Obsessive Compulsive Behavior yes/no
Schizophrenia yes/no
Suicide Attempts yes/no

3. What do you consider to be some of your child's strengths?

_____

_____

_____

4. What do you consider to be some of your child's weakness?

_____

_____

5. What would you like your child to accomplish in therapy?

_____