

**The Gatehouse**  
**Client Intake Questionnaire for Expressive Arts Therapy Individual Sessions**

Please fill in the information below and email it to Zada at [zada@thegatehouse.org](mailto:zada@thegatehouse.org)

**Name:**

**Date:**

**Address:**

**Email Address:**

**May we email you?**  Yes  No

**Cell Phone:**

**May we leave a voice message?**  Yes  No

**Date of Birth:**

**Age:**

**Pronouns:**

**Gender:**

**Emergency Contact Name:**

**Emergency Contact Phone Number:**

**Emergency Contact Relationship to you:**

**Are you a survivor of childhood sexual abuse?**  Yes  No

**Have you attended or completed a peer support group at The Gatehouse?**

Yes  No

**If you have completed Phase One at The Gatehouse, approximate date:**

**Are you currently taking any prescription medication?**

Yes  No If yes, please list medications in the space below:

**How would you rate your current physical health? (Please circle one)**

Poor                      Unsatisfactory                      Satisfactory                      Good                      Very good

**Are you currently experiencing overwhelming sadness, grief, or depression?**

No     Yes If yes, for approximately how long?

**Are you currently experiencing anxiety, panic attacks or have any phobias?**

No     Yes If yes, when did you begin experiencing this? What strategies do you find helpful to help you ground yourself?

**Do you engage in alcohol use? (Circle one) Yes/No If yes, how often?**

Daily                       Weekly                       Monthly                       Infrequently                       Never

**Do you engage in recreational drug use? (Circle one) Yes/No If yes, how often?**

Daily                       Weekly                       Monthly                       Infrequently                       Never

**Please indicate what coping strategies you have used in the past or present or not applicable to me using the table below.**

Coping Description	Not applicable	Past	Present
Avoidance/Denial			
Overworking/overscheduling yourself			
Sports/Exercise			
Dissociation/State of being disconnected			
Music /Video Games			
Reading/Writing/Art			
Isolation			
Sex Addiction			
Alcohol Use			
Anger/Rage			
Drug Use			
Compulsive Shopping			
Self-harm Behaviours (e.g., cutting, burning, skin picking, hair pulling, etc.)			
Perfectionism			

Suicide Thoughts/ideation			
Suicide Attempts			
Kleptomania /stealing			
Other (please describe)			

**What do you consider to be some of your strengths?**

**Are there any challenges that you anticipate will come up? If so, please describe.**