

Expressive Art Therapy Activities

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| Therapist Information | |
| Name: | |
| Specialization: | Contact Information: |
| Client Information | |
| Name: | Date of Birth: |
| Session Date: | Session Number: |
| Activity Planning | |
| Activity Name: | Objective: |
| <input type="checkbox"/> Drawing <input type="checkbox"/> Painting <input type="checkbox"/> Sculpting <input type="checkbox"/> Collage <input type="checkbox"/> Photography <input type="checkbox"/> Music <input type="checkbox"/> Dance / Movement <input type="checkbox"/> Poetry / Writing <input type="checkbox"/> Other: | <input type="checkbox"/> Explore emotions <input type="checkbox"/> Improve self-esteem <input type="checkbox"/> Develop social skills <input type="checkbox"/> Reduce anxiety <input type="checkbox"/> Process traumatic experiences <input type="checkbox"/> Enhance cognitive abilities <input type="checkbox"/> Other: |
| Materials Needed: | |
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| Instructions | |
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| Activity Execution | |
| Duration: | Setting: |
| <input type="checkbox"/> < 30 minutes <input type="checkbox"/> 30 - 60 minutes <input type="checkbox"/> > 60 minutes | <input type="checkbox"/> Individual <input type="checkbox"/> Group |
| Client Engagement: | |
| How did the client(s) engage with the activity? Were there any notable reactions or breakthroughs? | |
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| Therapeutic Observations | |
| Any specific emotions, themes, or behaviors observed during the activity? | |
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| Feedback and Reflections | |
| Client Feedback: | |
| How did the client(s) feel about the activity? What insights or reflections were shared? | |
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| Therapist Reflection: | |
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| Follow-Up | |
| Next Steps: | |
| | |
| Next Appointment | |
| Date: | Time: |