SPROUT PLAY THERAPY
& COUNSELING SERVICES

Name: ____
First Middle Last

DOB: ____________ Age: _______ Gender: ____________________________

School: ____________________ Teacher: ________________ IEP for Special Education Services (yes / no)

In what areas does your child's IEP cover?____

Home Address: ____

City: _________________________________State:____________________ Zip:_______________

Is the child in Child Protective Services (CPS) custody? Y / N CPS Worker: ____________________

CPS Worker Contact Number/Extension/Email:____

____

PARENT/GUARDIAN INFORMATION
Primary Guardian

____
First Middle Last

Relationship to Child: ____

Address: (only if different from above): ____

City: _________________________________State:______________ Zip:_______________

_______________________________ Ok to Leave a Message? Yes / No Ok to Text? Yes / No
Primary Phone Number

_______________________________ Ok to Leave a Message? Yes / No Ok to Text? Yes / No
Secondary Phone Number

Please note that all texting will be done through OhMD, a HIPAA Compliant app. You will need to download the app in order to text with this office.

Email Address: _________________________

Secondary Guardian (only for separate household)

____
First Middle Last

Relationship to Child: ____

Address: (only if different from above): ____

City: ________________________________State:_______________ Zip:________________

___________________________________ Ok to Leave a Message? Yes / No Ok to Text? Yes / No
Primary Phone Number

___________________________________ Ok to Leave a Message? Yes / No Ok to Text? Yes / No
Secondary Phone Number

Email Address: ___________________________

Are both the primary guardian and secondary guardian allowed to have contact with the child client? Yes / No

Please indicate if there are specific rules regarding contact, custody or other powers or limits of powers related to either guardian. Please provide a copy of the custody agreement if relevant, as enrollment in therapy cannot occur without the consent of both legal guardians when applicable.

____
____
____

PRIMARY INSURANCE INFORMATION/ AUTHORIZATION:

Primary Insurance:____

ID Number: ______________________________Group Number: ____________________________

Name of Policy Holder:____DOB:________________

Relationship to Client:____________________________________Phone:___________________________

Address of Policy Holder:____

City:___________________________________State:______________________Zip:_________________

Employer of Policy Holder:____

Secondary Insurance:____

ID Number:________________________________Group Number:____________________________

Name of Policy Holder:____

I hereby authorize Emily Gislason, LLC dba Sprout Play Therapy and Counseling Service to release necessary information to insurance carriers concerning my/my child's diagnosis and treatment in order to process my claims. I hereby authorize direct payment to Emily Gislason, LLC dba Sprout Play Therapy and Counseling Service from insurance carriers for services rendered if my account is not paid in full. I permit a copy of this authorization to be used in place of the original copy.

Signature of Policy Holder: ______________________________

BACKGROUND

List the names, ages, and relationship of all family members with whom the child lives:

Name	Relationship/Age	School or Occupation

What is it about your family's culture and values that would be important for us to know?

____
____
____
____
____

Previous Counseling Experience: ______________________________
____

How did you hear about us? ______________________________

Briefly explain the reason for seeking counseling: ______________________________
____
____

MEDICAL INFORMATION

______________________ Primary Care Physician

______________________ Hospital/Clinic Name

PHYSICIAN AUTHORIZATION

I hereby authorize Emily Gislason, LLC dba Sprout Play Therapy and Counseling Service to release records and/or information about my/my child's treatment to my physician for the purpose of treatment, planning, and coordinating psychotherapy for my/my child's physical health care needs. I may withdraw this consent at any time in writing or verbally advising my therapist.

Signature of Legal Guardian: ______________________________________ Date: _______________

Consent withdrawn on:_____________________________________

Medical/ Mental Health Concerns & Diagnoses:

____

Date of Diagnoses:

____

Medications:

____

Allergies:

____

DEVELOPMENTAL CONCERNS

Have you ever had concerns in the following areas pertaining to this child?

Pregnancy? Yes / No Explain:

____

Birth and Early Infancy? Yes / No Explain:

____

Childhood Health Issues? Yes / No Explain:

____

Functioning? Yes / No Explain:

____

Attention? Yes / No Explain:

____

Behaviors? Yes / No Explain:

___

TRAUMA HISTORY

Has your child experienced or witnessed any of the following: (please circle)

Car accident?

Physical illness?

Physical abuse?

Other accident?

Domestic violence/abuse?

Physical neglect?

Emotional abuse?

Sexual abuse/molestation?

Fire?

Community violence?

Natural disaster?

Other? Specify: ______________________________

PLEASE SPECIFY IF YOU CIRCLED ANYTHING ABOVE:

___

___

___

OTHER FAMILY CONCERNS (anything that pertains to the child's immediate family members)

Financial concerns? Yes / No

Specify:

___

Alcohol abuse? Yes / No

Specify:

___

Substance abuse? Yes / No

Specify:

___

Anxiety? Yes / No

Specify:

___

Depression? Yes / No

Specify:

___

ADHD? Yes / No

Specify:

Mania? Yes / No

Specify:

Schizophrenia or psychosis? Yes / No

Specify:

Significant Family Stressors? Yes / No

Specify:

Any additional information that would be helpful for the therapist to know?

Thank you!