SPROUT PLAY THERAPY
& COUNSELING SERVICES

CLIENT INFORMATION

Child's Full Name: _____

DOB: _____ Age: _____ Gender: _____

Home Address: _____

City/State: _____ Zip Code: _____

School: _____ Grade: _____ Teacher: _____

IEP for Special Education Services: ◯ Yes ◯ No IEP Areas: _____

Is child in CPS Custody? ◯ Yes ◯ No CPS Worker: _____

Worker Phone Number: _____ Worker Email: _____

PARENT/GUARDIAN INFORMATION

Primary Guardian

Name:
Address:
Phone:
Email:
Relationship to Child:

Secondary Guardian (only for separate housholds)

Name:
Address:
Phone:
Email:
Relationship to Child:

Are both the primary guardian and secondary guardian allowed to have contact with the 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 custody agreement*** if relevant, as enrollment in ***therapy cannot occur without the consent of both legal guardians*** when applicable.

_____

_____

_____

INSURANCE INFORMATION

Primary Insurance:
ID Number:
Group Number:
Name of Policy Holder:
Policy Holder DOB:
Employer:
Relationship to Child:
Address of Policy Holder:

Secondary Insurance:
ID Number:
Group Number:
Name of Policy Holder:
Policy Holder DOB:
Employer:
Relationship to Child:
Address of Policy Holder:

INSURANCE AUTHORIZATION

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 and within immediate family: (please use last page of form if needing more space)

Name	Relationship & Age	School or Occupation
Name	Relationship & Age	School or Occupation
Name	Relationship & Age	School or Occupation
Name	Relationship & Age	School or Occupation
Name	Relationship & Age	School or Occupation
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 withdraw on: _____

Medical/Mental Health Concerns & Diagnoses:

_____

Date of Diagnoses & Who Provided Diagnoses:

_____

Medications:

_____

Allergies:

_____

Previous Speech, Occupational, Physical, etc. Therapy and Dates:

_____

DEVELOPMENTAL CONCERNS

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

Pregnancy? ○ Yes ○ No Explain: _____

Birth & 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 check)

- ○ Car/Other Accident
- ○ Death/Loss
- ○ Fire
- ○ Physical Illness
- ○ Physical Neglect
- ○ Community Violence
- ○ Physical Abuse
- ○ Emotional Abuse
- ○ Natural Disaster
- ○ Domestic Violence/Abuse
- ○ Sexual Abuse/Molestation
- ○ Other (specify below)

Please specify if you marked anything above:

_____

_____

_____

_____

FAMILY CONCERNS

Please mark anything that pertains to the child's immediate or biological family members.

Financial Concerns	○ Yes ○ No	Explain:
Alcohol Abuse	○ Yes ○ No	Explain:
Substance Abuse	○ Yes ○ No	Explain:
Anxiety	○ Yes ○ No	Explain:
Depression	○ Yes ○ No	Explain:
ADHD	○ Yes ○ No	Explain:
Mania	○ Yes ○ No	Explain:
Schizophrenia or Psychosis	○ Yes ○ No	Explain:
Significant Family Stressors	○ Yes ○ No	Explain:

GOAL SETTING

If you could pick, what are the top 1-3 things you would want to address during the therapy process?

What would look different in your life if those areas were addressed? What might be going better/how will you know therapy is working?

What about your child and family will help everyone be successful? (think strengths and abilities)

ADDITIONAL INFORMATION

Please provide any additional information that would be helpful for us to know:

Thank You!