magnolia counseling & play therapy
— helping children and families blossom —

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INTAKE FORM

NAME: ______________________ ____ __________________________
First Name MI Last Name

DOB: ______________ **AGE:** ________ **GENDER:** ______________________

ADDRESS: ____

CITY: ____________________ **STATE:** ________ **ZIP:** ________________

PHONE NUMBER: ______________ ______________ ______________
Home Cell Work

EMAIL ADDRESS: ____

PLEASE LIST ALL PERSONS (INCLUDING YOURSELF) CURRENTLY LIVING IN YOUR HOUSEHOLD.

NAME **RELATIONSHIP** **DOB** **AGE** **OCCUPATION**

1.____
2.____
3.____
4.____
5.____

WHO IS LEGALLY AUTHORIZED TO RECEIVE INFORMATION ABOUT AND MAKE DECISIONS REGARDING THIS CHILD'S CARE?

______________________ ______________________ ______________________
NAME RELATIONSHIP PHONE NUMBER

______________________ ______________________ ______________________
NAME RELATIONSHIP PHONE NUMBER

WHO REFERRED YOU: ____

WHAT PROBLEMS BRING YOU TO SEEK TREATMENT: ____________________

____

IS TREATMENT COURT ORDERED: ☐ YES ☐ NO

SOCIAL, PLAY AND RECREATION: **Describe your child's social play and recreational interests.**

____

____

LAST GRADE LEVEL ACHIEVED: ____

PREGNANCY: ⬜ FULL TERM ⬜ PREMATURE ⬜ LATE **DELIVERY:** ⬜ VAGINAL ⬜ C-SECTION

Problems during pregnancy: ____

PARENTING TIME ARRANGEMENTS: Y/N
If applicable please provide a copy of any current court orders regarding the parenting plan.

CHILD/FAMILY MENTAL HEALTH HISTORY: (Please mark each that apply with "1" for child, "2" for immediate family, and "3" for extended family.)

____ INDIVIDUAL THERAPY	____ MARITAL THERAPY	____ FAMILY THERAPY	____ SEX THERAPY
____ DOMESTIC VIOLENCE	____ ANGER MANAGEMENT	____ GROUP THERAPY	____ GRIEF
____ LOSS	____ ANXIETY	____ DEPRESSION	____ ADHD
____ SEXUAL ABUSE	____ PHYSICAL ABUSE	____ BIPOLAR DISORDER	____ EATING DISORDER
____ PSYCHIATRIC HOSPITALIZATIONS	____ SCHIZOPHRENIA	____ ANTISOCIAL BEHAVIOR	____ DRUG USE
____ ALCOHOL USE	____ OTHER SUBSTANCES ____________________	____ OTHER ADDICTIONS ____________________	

FAMILY MEDICAL HISTORY: (Please mark each that apply with "1" for child, "2" for immediate family and "3" for extended family.)

___ ASTHMA	___ HIGH BLOOD PRESSURE	___ KIDNEY DISEASE	___ DENTAL PROBLEMS
___ CANCER	___ THYROID PROBLEMS	___ LIVER DISEASE	___ TUBERCULOSIS
___ DIABETES	___ SEASONAL ALLERGIES	___ HEART DISEASE	___ HEAD INJURY
___ HEARING ISSUES	___ SEIZURES	___ ALLERGIES	___ OTHER ________________

CURRENTLY PRESCRIBED MEDICATIONS AND PRESCRIBING PHYSICIAN:

____

____

____

CURRENT GENERAL FUNCTIONING: Please mark each that apply.)

___ CHEERFUL/HAPPY MOOD MOST OF THE TIME	___ SAD OR TEARFUL MOST OF THE TIME	___ FEELINGS OF HOPELESSNESS OR EMPTINESS
___ WITHDRAWN BEHAVIORS OR ISOLATION	___ DIFFICULTY CONCENTRATING	___ UNDER ACTIVE OR SLUGGISH
___ DECREASE IN INTERESTS OR ACTIVITIES	___ FEELINGS OF GUILT	___ DOWN MOST DAYS
___ DECREASED APPETITE	___ INCREASED APPETITE	___ WEIGHT GAIN
___ WEIGHT LOSS	___ NO ENERGY	___ OVERLY FATIGUED DURING THE DAY
___ SUICIDAL THOUGHTS	___ SUICIDAL ATTEMPTS	___ INTENTIONAL SELF-HARM (i.e. CUTTING)
___ POOR SELF-CARE/POOR HYGIENE	___ POOR MEMORY	___ EXTREME UPS AND DOWNS IN MOOD
___ WORRY	___ PANIC	___ AVOIDANT
___ STRESS	___ IRRITABILITY	___ ANGER
___ TAKES MORE THAN AN HOUR TO FALL ASLEEP	___ NIGHT WAKING FOR LONGER THAN 30 MINUTES	___ HARD TO WAKE UP IN THE MORNING
___ UNABLE TO SLEEP IN OWN BED THROUGH THE NIGHT	___ FEARFUL OF PLACES, SITUATIONS, OR PEOPLE	___ FAST/RAPID SPEECH, FEELS RESTED AFTER 3-4 HRS SLEEP
___ FEARLESS OR ENGAGING IN RECKLESS ACTIVITIES	___ EXAGGERATED VIEW OF ABILITIES	___ LYING
___ THREAT TO HURT SOMEONE WITH INTENT/PLAN	___ PHYSICAL AGGRESSION	___ CONFLICT WITH AUTHORITY FIGURES
___ STEALING	___ PHYSICAL CRUELTY TO ANIMALS	___ PROPERTY DAMAGE
___ VERBAL THREATS TO HARM OTHERS	___ THOUGHTS OF HARM TO OTHERS	___ INABILITY TO REMAIN SEATED
___ EXPLOSIVE OUTBURSTS	___ DISTINCT PERIODS OF NONSTOP ACTIVITY	___ POOR SOCIAL SKILLS

___ LEGAL PROBLEMS	___ EXTREME CONFLICT WITH OTHERS	___ GRANDIOSITY/UNREALISTIC SENSE OF SUPERIORITY
___ PROBLEMS WITH SCHOOL PERFORMANCE	___ INABILITY TO COMPLETE TASKS	___ INABILITY TO SUSTAIN ATTENTION
___ EASILY DISTRACTED	___ OVERACTIVE/HYPERACTIVE	___ IMPULSIVITY
___ COMPULSIONS	___ DENIAL	___ NIGHTMARES
___ SLEEPWALKING	___ WETTING ACCIDENTS	___ SEXUAL INAPPROPRIATE TOUCHING OF OTHERS
___ SEXUAL PLAY WITH TOYS OR OBJECTS	___ EXCESSIVE MASTURBATION	___ PROBLEMS WITH RELATIONSHIPS
___ JEALOUSY	___ EXTREME CONFLICT WITH SIBLINGS	___ BLENDED FAMILY
___ DIVORCE	___ FAMILY CONFLICT	___ TRUST
___ SHAME	___ CRISIS	___ CONCERNS WITH CHILD CARE
___ DISABILITY	___ EMPLOYMENT	___ INTENTIONAL PURGING
___ INTENTIONAL VOMITING	___ HOARDING FOOD	___ BINGE EATING
___ ANOREXIA	___ BULIMIA	___ OBESITY
___ BODY IMAGE	___ SELF-ESTEEM	

AUTHORIZATION AND CONSENT TO TREAT A MINOR

By signing below you are authorizing Magnolia Family Counseling to provide your child with mental health services. I acknowledge that both natural parents, even though divorced, may have a right to obtain from Magnolia Family Counseling information regarding the nature and course of treatment of the child named above. In instances of divorce, it is essential that the legal custodian of the child grant permission for the services. If you are a divorced parent, stepparent, grandparent, guardian or other, you are required to provide a copy of the court order which names you the legal custodian of the above named child. (<u>MUST BE SIGNED BEFORE SERVICES CAN BE PROVIDED</u>)

Parent/Guardian Signature X ________________________________ **Date** ______________

Parent/Guardian Signature X ________________________________ **Date** ______________

Child/Youth Signature X ____________________________________ **Date** ______________

BILLING INFORMATION *If billing information is not complete and accurate, we reserve the right to **NOT** schedule additional appointments until it is supplied.*

PAYMENT OPTION: ⬜ INSURANCE ⬜SELF - PAY ⬜ OTHER _______

PRIMARY INSURANCE POLICY INFORMATION
Primary Insurance Company: ____
Insurance Member I.D. Number: _______________________ Group Number: ___________________
Effective Date: ____________________

PRIMARY INSURANCE INSURED PERSON INFORMATION
Client's relationship to insured (i.e. self, spouse, child, other): _________________________________
Insured's Name: ____ Gender: M/F
Street Address: ____
City: ________________________________ State: _____________ Zip Code: _________________
Phone Number: ________________________________ Date of Birth: ________________________
Employer: ____

By signing this agreement below you agree to and acknowledge each of the following conditions:

1. The information provided regarding insurance coverage is accurate.
2. Payment for any and all required co-payments, deductibles, coinsurance, and non-allowable charges is required and due at the time the service is delivered. Payment must be in the form of cash, check, or credit cards.
3. If your insurance company denies, refuses, or fails to make payments for the services rendered, Magnolia Family Counseling will notify you in writing.
4. You assume responsibility for any and all fees rendered associated with services including document preparation fees provided by Magnolia Family Counseling.
5. You will be solely responsible for the full cost of the session if you do not show up for your appointment or do not cancel at least 24 hours in advance.
6. Insufficient fund checks will be assessed a $30.00 charge.
7. You are responsible for notifying Magnolia Family Counseling of any changes in name, address, telephone number or insurance coverage.
8. By signing this agreement, you agree to allow Magnolia Family Counseling to release any and all information necessary for filing insurance claims and collecting fees from your insurance company.
9. Magnolia Family Counseling shall have the authority to charge and assess collection costs and expenses, including reasonable attorney's fees, and penalties and interest for the late payment or nonpayment thereof.

Print Name: ____ Date: ___________________

Parent/Guardian Signature: ____