

# Mandala Play Therapy Solutions, LLC

10400 N Vineyard Blvd, Ste. A  
Oklahoma City, OK 73120  
(405) 242-5305

Date: \_\_\_\_\_

## BACKGROUND INFORMATION

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

SSN: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Sex:  M  F Ethnicity \_\_\_\_\_Marital Status:  Single  Married  Separated  Divorced  Widowed

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_

Check if we can leave a message on your:  Home phone  Work Phone  Cell Phone

### EMERGENCY CONTACT (If client is under 18 or under legal guardianship, list Parent/Guardian)

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work/Other Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

### HEALTH CARE RESOURCES

 Private Insurance  Public Insurance (Medicaid)  None

Provider: \_\_\_\_\_ Policy/Medicaid Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Policy Holder (cite name as is appears on the insurance card): \_\_\_\_\_

Policy Holder Date of Birth \_\_\_\_\_

Other information: \_\_\_\_\_

## CURRENT LIVING SITUATION & FAMILY HISTORY

I live (check one):  Alone  w/Significant Other  in Community Based Shelter Other: \_\_\_\_\_ Number of Persons in Home: \_\_\_\_\_

### CHILDREN LIVING IN HOME (use back if needed)

Last Name: \_\_\_\_\_, First \_\_\_\_\_, MI \_\_\_\_\_ Age \_\_\_\_\_  Male  FemaleLast Name: \_\_\_\_\_, First \_\_\_\_\_, MI \_\_\_\_\_ Age \_\_\_\_\_  Male  FemaleLast Name: \_\_\_\_\_, First \_\_\_\_\_, MI \_\_\_\_\_ Age \_\_\_\_\_  Male  Female

Client Name \_\_\_\_\_ Client ID \_\_\_\_\_ CONFIDENTIAL

OTHERS LIVING IN HOME (use back if needed)

Name: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_

CHILDREN LIVING OUTSIDE OF HOME (use back if needed)

Last Name: \_\_\_\_\_, First \_\_\_\_\_, MI \_\_ Age \_\_  Male  Female

City & State \_\_\_\_\_ If minor, with whom \_\_\_\_\_

Last Name: \_\_\_\_\_, First \_\_\_\_\_, MI \_\_ Age \_\_  Male  Female

City & State \_\_\_\_\_ If minor, with whom \_\_\_\_\_

**PRESENTING PROBLEM/HISTORY OF PRESENTING PROBLEM**

Who referred you? \_\_\_\_\_

Please write a couple of sentences concerning the reason for your request of services.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please check your employment status  Full-time  Part-Time  Unemployed  Not in Labor Force

If employed, who is your employer?

\_\_\_\_\_

What is the highest level of education you have received? \_\_\_\_\_

In the past 60 days, how many days have you or the minor been absent from school and/or daycare? \_\_\_\_\_

Have you served in the military? \_\_\_\_ If so what is your current status? \_\_\_\_\_

Are you currently receiving any government assistance? \_\_\_\_ If so, what programs? \_\_\_\_\_

Please check all that apply  Medicaid  Medicare  SSI  SSDI

Are you currently using tobacco products? \_\_\_\_ If so, please describe your use. \_\_\_\_\_

How many days have you used tobacco in the past 30 days? \_\_\_\_\_

Are you currently using alcohol? \_\_\_\_ If so, please describe your use. \_\_\_\_\_

Are you currently using other substances? \_\_\_\_ If so, please describe your use. \_\_\_\_\_

How many times have you been in jail in the past 30 days? \_\_\_\_\_ 12 months? \_\_\_\_\_

Have you ever experienced (check all that apply):  Physical Abuse,  Emotional / Verbal Abuse,  Sexual Abuse / Molestation / Sexual Misconduct,  Neglect,  I would rather not answer these

Have you ever attempted suicide? YES or NO

If "yes," identify month & year of attempt(s) \_\_\_\_\_

Have you ever had thoughts of suicide? YES or NO

If "yes," identify month & year of latest thought(s) \_\_\_\_\_

**MEDICAL**

Are you currently under the care of a physician for medical problems/medication?  Yes  No

If yes, describe: \_\_\_\_\_

Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Are you currently taking medications?  Yes  No

If yes, list those you are currently taking (use back if needed):

Medication	Strength & Dosage	Length Taken	Purpose & Side Effects
<input type="checkbox"/> _____	_____	_____	_____
<input type="checkbox"/> _____	_____	_____	_____
<input type="checkbox"/> _____	_____	_____	_____

Please list any allergies: \_\_\_\_\_

Are you currently receiving behavioral/mental health services elsewhere?  Yes  No

If yes, provide the following:

Date	Type*	Where	Purpose/Diagnosis
_____	_____	_____	_____

\* out-patient, in-patient, crisis intervention, day treatment, group, etc.

Have you received behavioral/mental health services in the past?  Yes  No

If yes, provide the following (use back if needed):

Date	Type*	Where	Purpose/Diagnosis
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

How many self-help meetings have you attended in the past 30 days? \_\_\_\_\_

Please include any other information you feel is important for therapist to know.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_