# Allen E. Rush, MA, LPC

## 4R Farm Equine-Assisted Counseling

### Registration Form

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**Client Information**

Child's Name: ______________________________________________________ Age:________ Gender: M______ F_______

Nickname: __________________________________________________________ Date of Birth: ___________________________

Physical Street Address: ___________________________________________________ City: _______________ Zip: __________

Mailing Address (if different): ______________________________________________ City: _______________ Zip:__________

Parent/Guardian contact: Home: ______________________ Cell: _____________________ Work:______________________

Email: _________________________________________________________________________________________________

May we leave a message on your voicemail?_______________________ May we text and email you?_____________________

Child's School________________________________________ Grade: ________________ Teacher: _____________________

Emergency Contact (s): ____________________________________________________________ Phone: __________________

How did you hear about Mr. Rush? ____________________________________________ May we thank this person?__________

**Insurance Information**

Insurance Company: ___________________________________ ID#:________________________ Group #:__________________

Insured's Name: ___________________________________________________DOB: ______________ Male ____ Female ____

Insured's Employer: _____________________________________________ Insured's Employer Work #:___________________

Client's relationship to the insured: _____________________________________________________________________________

**Does the patient have any secondary insurance?___________________ If yes, complete the following:**

Insurance Company: _________________________________ ID#: ________________________ Group #:__________________

Insured's Employer: _____________________________________________ Insured's Employer Work #:___________________

**Personal History**

What problem(s) is your child experiencing that brings you to see Mr. Rush? ___________________________________________

_______________________________________________________________________________________________________

_______________________________________________________________________________________________________

_______________________________________________________________________________________________________

_______________________________________________________________________________________________________

_______________________________________________________________________________________________________

How long has this been going on? ___________________________________________________________

Has the child had previous evaluations or treatment? Yes ______ No _____ If Yes, please describe: ______________________

___________________________________________________________________________________

**Medical**

Name of child's Pediatrician/Physician: ____________________________________________________

Address: ___________________________________________________ Phone: _____________________________

List any current health conditions:

___________________________________________________________________________________

What medications (and dosages) are currently being taken (and for what purpose)?________________________________

___________________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

**Family**

Biological Parents:

Mother: ________________________________ Age_________ Father: _________________________________ Age_______

Adoptive Parents (if applicable):

Mother: ________________________________ Age _________ Father: _________________________________ Age _______

Stepparents (if applicable):

Stepmother: __________________________________________ Stepfather: __________________________________________

Who has legal guardianship of your child? _______________________________________________________

Who does the child currently live with? _________________________________________________________

**Consent to Services**

My signature attests to the following: (1) I have read the Agreement for Counseling Services, understand it, and consent to counseling services for myself and/or my family; (2) I authorize Allen E. Rush, MA, LPC to release any pertinent information acquired during the course of my evaluation and treatment to my insurance company; (3) I am ultimately responsible for payment of charges for services rendered by the provider; and (4) I understand that Allen E. Rush, MA, LPC is a solo practitioner in independent practice and is not part of a group practice.

Signed: _______________________________________________________________Date: _____________________

(Parent/Guardian)