Basset
Psychological Services, LLC

CLIENT INFORMATION

Client's Name: _____ Date: _____

Birthdate: _____ Age: _____ Birth Sex: _____ Gender Id: _____ Race: _____

Form completed by (if someone other than client): _____ Relationship: _____

Client's street address: _____

City: _____ State: _____ Zip: _____

Client's phone number if patient is 16 or older: _____ Okay to leave a message? ☐ Yes ☐ No

Client's email if patient is 16 or older (**see email policy**): _____ Okay to email? ☐ Yes ☐ No

Referred by: _____ Physician name: _____

Complete parent information below for minors and young adults up to 26 years old:

Parent/Guardian: _____ Relationship: _____ Birthdate: _____

❑ Check *box if ADDRESS is same as above OR list below.*

Street address: _____ City: _____ State: _____ Zip: _____

Phones: ❑ Cell: _____ ❑ Home: _____ ❑ Work: _____
*Check boxes to indicate where voicemail messages can be left.

Email address (**see email policy**): _____ Okay to email? ☐ Yes ☐ No

Employment Status: ❑ Not Employed ❑ Part time ❑ Full time ❑ Retired ❑ Student

Profession: _____ Employer: _____

Parent/Guardian: _____ Relationship: _____ Birthdate: _____

❑ *Check box if ADDRESS is same as above OR list below.*

Street address: _____ City: _____ State: _____ Zip: _____

Phones: ❑ Cell: _____ ❑ Home: _____ ❑ Work: _____
*Check boxes to indicate where voicemail messages can be left.

Email address (**see email policy**): _____ Okay to email? ☐ Yes ☐ No

Employment Status: ❑ Not Employed ❑ Part time ❑ Full time ❑ Retired ❑ Student

Profession: _____ Employer: _____

Parents Marital Status: ❑ Married ❑ Divorced ❑ Remarried ❑ Never married ❑ Separated

If parents are not currently married to each other, what is the custody arrangement? _____

_____

Any other adults with custodial responsibilities (e.g., stepparents):

Name: _____ Relationship: _____ Birthdate: _____

❑ *Check box if ADDRESS is same as above OR list below.*

Street address: _____ City: _____ State: _____ Zip: _____

Phones: ❑ Cell: _____ ❑ Home: _____ ❑ Work: _____
*Check boxes to indicate where voicemail messages can be left.

Email address (**see email policy**): _____ Okay to email? ☐ Yes ☐ No

Employment Status: ❑ Not Employed ❑ Part time ❑ Full time ❑ Retired ❑ Student

Profession: _____ Employer: _____

Other adults involved in treatment:

Other adult family members who may be involved in treatment or bring client to appointments and their phone number.

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

ALL CLIENTS COMPLETE

Emergency Contact:

Name: _____ Relationship to Client: _____

Phone number: _____

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Child Development History and Background Information

Please complete this form and bring to your initial appointment. Contact our office with any questions or concerns.

Client Name: _____ Date: _____

Person completing form: _____ Relationship: _____

Presenting Problem

*Describe your reasons for seeking services, **starting** with the **most important**.*

A.

B.

C.

D.

*Please check any **past** or **current issues** that apply to the client:*

- ❑ Anxiety/ Worry/ Nervousness
- ❑ Panic Attacks
- ❑ Irritability/ Impatience/ Anger
- ❑ Difficulty w/ Focus or Concentration
- ❑ High Energy/ Hyperactivity
- ❑ Low Energy/ Fatigue
- ❑ Low Motivation
- ❑ Low Self Esteem
- ❑ Depression/ Feeling Sad or Blue
- ❑ Eating problems
- ❑ Weight Concerns
- ❑ Recent Death(s) of a loved one
- ❑ Parental Divorce/ Separation
- ❑ Major family changes
- ❑ Physical Abuse*
- ❑ Sexual Abuse*
- ❑ Neglect of basic needs*

***Please note limited confidentiality**

- ❑ Aggression
- ❑ Defiant or oppositional behavior
- ❑ Frequent Tantrums
- ❑ Conduct Problems
- ❑ Parent-child conflict
- ❑ Sibling conflict
- ❑ Learning problems/ Poor Grades
- ❑ Suicidal Thoughts or Statements
- ❑ Sleep Problems (Too much/ Too little)
- ❑ Frequent moves/relocations
- ❑ Stealing
- ❑ Lying
- ❑ Chronic Medical Issues
- ❑ Other: _____

Family History and Information

Please list all **immediate family members** and other individuals who live with or play an important role in the client's life.

Household Member Names	Relationship	Age	Occupation/ School	Level of Education	Quality of Relationship

What are some things your family **enjoys doing together**?

What are the primary **methods of discipline** for your child? *(check all that apply)*

❑ Time Out/Grounding ❑ Removing Privileges ❑ Physical (ex: spanking) ❑ Extra Chores ❑ Lecture

❑ Yelling ❑ Discussion ❑ No Discipline ❑ Other: _____

Who is **responsible for discipline** of your child? _____

How does child **respond to discipline**? _____

Do all **caregivers agree** on discipline? _____

Please list **residences** below:

From	To	Location	With whom?	Reason for moving	Any problems?

Please list any **residential placements, institutional placements, or foster care**:

From	To	Program name or location	Reason for placement	Problems?

Prenatal History and Early Development

	Yes	No	If yes, please provide details
Were there any problems during pregnancy?			
Did the mother smoke during pregnancy?			
Did the mother drink alcohol or use recreational drugs during pregnancy?			
Did the mother take any prescribed medications during pregnancy?			
Length of pregnancy: weeks gestation			
Were there any problems during labor?			
Type of delivery:			
Were there any problems during delivery?			
Child's birth weight: pounds ounces			
Any problems for the baby after the delivery?			
Did the mother experience any problems after the delivery?			

How would you describe your child's temperament as a baby? *(check all that apply)*

❑ Easy ❑ Fussy ❑ Quiet ❑ Shy ❑ Alert ❑ Sleepy ❑ Other _____

Sleep patterns or problems in infancy:

Developmental Milestones

At **what ages** did your child learn to: *(check one)*

	Early	Within Normal Limits	Late	
Crawl	❑ ≤ 5 months	❑ 6 – 11 months	❑ 12+ months	
Stand	❑ ≤ 8 months	❑ 8 – 12 months	❑ 13+ months	
Walk	❑ ≤ 8 months	❑ 9 – 16 months	❑ 17+ months	
First Words	❑ ≤ 5 months	❑ 6 – 12 months	❑ 13+ months	
Toilet Training	❑ ≤ 23 months	❑ 24 – 36 months	❑ 37+ months	❑ NA for very young

Any **delays or concerns** re: developmental milestones? ❑ Yes ❑ No

If yes, please explain: _____

Any **disruption in bonding** in the first 2 years of life (separation from parent, parental stress, postpartum depression, child difficult to comfort)? ❑ Yes ❑ No

If yes, please explain: _____

Behavioral/Mental Health History

Has client had a psychological evaluation? ❑ Yes ❑ No

Has client been diagnosed with any mental or behavioral health problems (ADHD, Depression, Anxiety, disruptive behavioral disorder, etc.)? ❑ Yes ❑ No

If yes, please describe: _____

Any past or current therapy or counseling? ❑ Yes ❑ No

If yes, please list such treatment below:

When (age of child)	**With Whom** (name of treatment provider)	**Why** (presenting problem or diagnosis)	**Outcome** (was treatment helpful/effective)

Has child been prescribed medication for a behavioral/mental health condition (e.g., ADHD, Depression, Anxiety, etc.)? ❑ Yes ❑ No

If yes, please list current and past behavioral health medications below:

Medication	**Prescribing Physician**	**Start Date**	**End Date**	**Helpful?**

Has child ever been hospitalized for emotional/behavioral problems? ❑ Yes ❑ No

If yes, when & why: _____

Family History of behavioral/mental health and substance abuse

Please indicate any family history of **mental/behavioral health concerns or substance abuse** (parents, siblings, grandparents, aunts, uncles):

Family member (relationship to child)	**Condition**	**Ever received treatment/intervention?**

Physical Health History and Information

Has your child been **diagnosed** with **any ongoing medical problems** (ex: irritable bowel, migraines, etc.)? ❑ Yes ❑ No

If yes, please describe: _____

Please **check off** if your **child has had any of the following**:

❑ Asthma or breathing problems	❑ Vision Problems	❑ Hearing Problems
❑ Allergies	❑ Seizures or Convulsions	❑ Frequent Ear Infections
❑ Tics or Twitches	❑ Been Hospitalized	❑ Fever above 104
❑ Major injuries or accidents	❑ Had Surgery	❑ Physical Therapy (PT/ OT)
❑ Weight Problems	❑ Lost Consciousness	❑ Speech Therapy

Explain any checked above:

Please list any **current medication**, not listed above:

Current Medications	Reason	Who prescribes

Do you have any **concerns** about your child's **eating habits**?

❑ Picky eater ❑ Eats too little ❑ Eats too much ❑ Binges ❑ Vomits Frequently

❑ Poor diet ❑ Restricted diet ❑ Other: _____

School History and Information

Current School	Current Teacher	Grades Attended

Previous Schools	Grades Attended

	Yes	No	If yes, please explain
Current disciplinary problems at school?			
Past disciplinary problems at school?			
Current academic problems at school?			
Past academic problems at school?			
Has your child been **held back**?			If yes, what grade?
Does your child have an **IEP or 504 plan**?			
If yes, describe reason and accommodations:			

For older children – What does your child do to **earn money** (ex: job, chores, etc.)?

Social Functioning

List any concerns about your **child's friendships or interactions with peers**?

List **hobbies, sports; recreational, musical, interests, and toy preferences**; etc.:

What are your child's personal **strengths**?

Substance Use

For older children and teens, any concerns about:

	Yes	No	If yes, please explain
Alcohol use			
Drug use			
Smoking			
Vaping			

Legal

Please list any **legal difficulties** among immediate family members such as arrests or incarcerations or involvement in lawsuits/litigation?

Other

Is there anything else I should know that does not appear on this or other forms, but that is or might be important?