

The MINDset Center

Gina W. Basey, Psy.D.

New Patient Registration Form

(Minor Clients Under Age 18)

Name of Minor Client: _____

Nickname? _____

Address:			
Street:	City	State	Zip
Phone: (H)	Ok to Leave Message?	YES	NO
(C)	Ok to Leave Message?	YES	NO
(Other)	Ok to Leave Message?	YES	NO
School:		School Phone	
Teacher:		Grade	
Date of Birth:		Gender	(circle) M F
Insurance Provider		Insurance Holder:	
Insurance Policy Number		Group Number:	
Pediatrician:		Phone:	
Pediatrician Address:		Referral Made By Physician? Y/ N	

Mother/Parent A's Name _____ **Date of Birth** _____

Parent's Address _____

Parent's Home Phone _____

Work _____

Cell Phone _____

Email _____

School level completed _____

Occupation _____

Father/Parent B's Name _____ **Date of Birth** _____

Parent's Address _____

Parent's Home Phone _____

Work Phone _____

Cell Phone _____

Email Address _____
School level completed _____
Occupation _____

Marital Status of Parents:

Married Separated Divorced Widowed Single

How long married? _____ How long divorced? _____ Child's age at divorce _____

If parents are divorced, separated, or single who has legal custody of the child?

Mother/Parent A Father/Parent B Mother/Parent A and Father/Parent B Other _____

What are your primary concerns about your child?

Is the child aware of this meeting? YES NO

If yes, what have you said to the child about this meeting/evaluation?

Is your child motivated for treatment? YES NO

Previous Evaluations (Psychiatric, Psychological, Therapy, Speech, Occupational or Otherwise):

Name of Provider	Type of Treatment	Dates of Services	Contact Information

Medical Issues

Hospitalizations _____

Chronic Medical Conditions (i.e. asthma, ear infections) _____

Allergies _____

Current Medical Concerns _____

Is your child on any medications CURRENTLY? YES NO

If yes, please list:

Name of Medication	Dosage

Family History of Medical/Psychological Issues (Please Check)

Condition	Mother	Father	Sister(s)	Brother(s)	Others
ADHD					
Anxiety					
Depression					
Behavior Problems					
Learning Disabilities					
Drugs/Alcohol					
Psychiatric Hospitalizations					

DEVELOPMENTAL HISTORY

BIRTH: _____ WEEKS

BIRTH COMPLICATIONS?

PREGANCY NORMAL: YES NO
IF NO PLEASE
DESCRIBE: _____

SUBSTANCE USE DURING PREGNANCY? YES NO
IF YES, PLEASE CHECK:

- Cigarettes How many? _____
 Alcohol How many drinks? _____
 Drugs Please describe types of drug use and frequency _____

Ages at Milestones

Gross motor:

Crawled _____
Walked alone _____
Sat by self _____
Ran well _____

Fine motor:

Fed self with spoon _____
Scribbled _____
Tied shoes _____
Spoke clearly _____

Language development:

Single words _____
Used sentences _____
(2+ words) _____

Potty trained: Urine for day _____ Bowels for day _____
Urine for night _____ Bowels for night _____

Rate of development overall: Slow Normal Fast

EDUCATIONAL HISTORY

HAS YOUR CHILD EVER BEEN RETAINED FROM A GRADE? YES NO
IF YES WHICH GRADE? _____

DOES YOUR CHILD RECEIVE ANY SPECIAL EDUCATIONAL SERVICES?
YES NO
IF YES PLEASE DESCRIBE:

DOES YOUR CHILD HAVE AN I.E.P. OR 504 PLAN? YES NO

DOES YOUR CHILD RECEIVE ANY PRIVATE TUTORIAL SERVICES?
YES NO
IF YES, PLEASE LIST

NAME	TYPE OF TUTOR	CONTACT INFORMATION

PLEASE DESCRIBE YOUR CHILD'S PERSONAL STRENGTHS AND INTERESTS:

NAME OF PERSON COMPLETING THIS FORM:

DATE: _____