LeeBascom MSW, LCSW

# Child/Teen Developmental History Record

Child's name:_____ Birthdate:_____ Age:_____

Person(s) completing this form:_____Today's date:_____

Parent #1 name:_____Birthdate_____

Home phone_____ Work phone_____

Cell phone_____ Please circle best way to contact

Address_____

_____

Currently employed? No Yes as_____

Parent #2 name_____Birthdate_____

Home phone_____Work phone_____

Cell phone_____ Please circle best way to contact

Address_____

_____

Currently employed? No Yes
as_____

Parents are currently Married Divorced Remarried Never married Other

Child's custodian/guardian is_____

1121 Olivette Executive Parkway
Suite 205
St. Louis MO 63132

314 991-9058
lee@leebascom.com

Stepparent's name_____Birthdate_____

Home phone_____Work phone_____

Address_____

_____

Currently employed No  Yes as_____

Other people living in home with child (grandparents, siblings names and ages, etc.)

_____

_____

_____

Was child adopted or in foster care?  Y or N  If so, at what age?_____

Any current contact with birth family?

_____

Was the child premature? Y or N
Weight and height at birth_____

Any birth complications or problems?

_____

Any developmental delays?

_____

Any speech, hearing, or language
difficulties_____

_____

Current Conditions_____

_____

Current medications and
dosages_____

_____

Treated by whom?

_____

Pediatrician_____

Neurologist_____

Psychiatrist_____

Any hospitalizations for psychiatric reasons?

_____

_____

Current sleeping problems_____

_____

Current eating/diet problems_____

_____

Any previous or current counseling or therapies?  Y or N  With whom?

_____

_____

Helpful?_____

Residential placements, institutional placements, or foster care? Y or N _____

_____

_____

Current Grade_____ Current School_____

IEP? Y or N_____ If so, for what areas?

_____

_____

Is your child working at grade level? Please explain_____

_____

Current school strengths or difficulties_____

_____

_____

List hobbies, sports; recreational, musical, TV, and toy preferences, etc._____

_____

_____

Is there anything else I should know that doesn't appear on this or other forms, but that is or might be important?_____

_____

_____

_____

How when we know when things are better?

_____

_____

_____

## FINANCIAL AGREEMENT AND CANCELLATION POLICY

**You will be expected to pay for each session at the time it is held,** unless we agree otherwise or you have insurance coverage which requires another arrangement. You will always be expected to pay the insurance co-pay at the time of service.

Returned checks will be charged a $30 fee for insufficient funds.

In the event that I bill your insurance company and they do not pay, you will be responsible for payment in full.

If I am not a participating provider on your insurance plan, I will provide you with a billing statement that you can file with your insurance company. I will expect you to pay me at the time of each session unless we make other arrangements.

Please let me know if you are not able to keep your scheduled appointment at least 24 hours in advance.

Appointments missed without notification or cancelled within 24 hours may be charged the full cost of the appointment.

I will understand if you come to the appointment late but please know that we will end on time so that we will not be cutting into someone else's appointment.

Signature_____

Print Name_____

Date_____

**AUTHORIZATION TO USE UNENCRYPTED EMAIL TO COMMUNICATE PROTECTED HEALTH INFORMATION**

Thank you for your request to communicate with me via email. I want to make sure you know that email communications between us are not encrypted and therefore are not secure communications. If you elect to communicate with me from your workplace computer, you also should be aware that your employer and its agents may have access to email communications between us. Finally, email communications may become a part of your client file. The types of transactions available by email are limited consultation, prescription refills, and patient education.

Incoming email communications will be reviewed and answered as soon as possible. If you have not heard from me with 24 hours, please call me at (314) 991-9058 during regular office hours (8:30-4:30).

EMAIL SHOULD NEVER BE USED IN THE CASE OF AN EMERGENCY OR FOR URGENT REQUESTS FOR INFORMATION.

Please sign below if you accept these terms and conditions.

ACCEPTED:
Signature of patient/guardian_____

Patient name (if child)_____

Authorized e-mail address of client/
guardian_____

Date:_____

**Notice of Privacy Practices**
**Receipt and Acknowledgment of Notice**

**Patient/Client Name:**_____
**DOB:** _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Lee Bascom's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Lee Bascom, MSW, LCSW at (314) 991-9058.

_____
**Signature of Patient/Client** **Date**

_____
**Signature or Parent, Guardian or Personal Representative** **Date**

_____
If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

❑ **Patient/Client Refuses to Acknowledge Receipt**:

**Consent to Treatment of a Child or Teen**

Name of child/teen client_____

Lee Bascom, MSW, LCSW and I have discussed my child's situation. I have been informed of the risks and benefits of several different treatment choices. The treatment chosen includes these actions and methods:

1.
2.
3.

These actions and methods are for the purposes of:

1.
2.
3.

I have had the chance to discuss all of these issues, have had my questions answered, and believe I understand the treatment that is planned. Therefore, I agree to play an active role in this treatment as needed, and I give this clinical social worker permission to begin this treatment, as shown by my signature below.

_____

Signature of parent/guardian Date

I, the therapist, have discussed the issues above with the child's parent or guardian. My observations of this person's behavior and responses give me no reason, in my professional judgment, to believe that this person is not fully competent to give informed and willing consent to the child's treatment.

_____

Signature of therapist Date

_____Copy accepted by parent/guardian _____Copy kept by social worker

Child's Name _____ Record Number _____
Today's Date _____ Filled out by _____
Date of Birth _____

# Pediatric Symptom Checklist

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions or learning, you may help your child get the best care possible by answering these questions. Please mark under the heading that best fits your child.

| | | | Never (0) | Sometimes (1) | Often (2) |
|---|---|---|---|---|---|
| 1. | Complains of aches/pains | 1 | _____ | _____ | _____ |
| 2. | Spends more time alone | 2 | _____ | _____ | _____ |
| 3. | Tires easily, has little energy | 3 | _____ | _____ | _____ |
| 4. | Fidgety, unable to sit still | 4 | _____ | _____ | _____ |
| 5. | Has trouble with a teacher | 5 | _____ | _____ | _____ |
| 6. | Less interested in school | 6 | _____ | _____ | _____ |
| 7. | Acts as if driven by a motor | 7 | _____ | _____ | _____ |
| 8. | Daydreams too much | 8 | _____ | _____ | _____ |
| 9. | Distracted easily | 9 | _____ | _____ | _____ |
| 10. | Is afraid of new situations | 10 | _____ | _____ | _____ |
| 11. | Feels sad, unhappy | 11 | _____ | _____ | _____ |
| 12. | Is irritable, angry | 12 | _____ | _____ | _____ |
| 13. | Feels hopeless | 13 | _____ | _____ | _____ |
| 14. | Has trouble concentrating | 14 | _____ | _____ | _____ |
| 15. | Less interest in friends | 15 | _____ | _____ | _____ |
| 16. | Fights with others | 16 | _____ | _____ | _____ |
| 17. | Absent from school | 17 | _____ | _____ | _____ |
| 18. | School grades dropping | 18 | _____ | _____ | _____ |
| 19. | Is down on him or herself | 19 | _____ | _____ | _____ |
| 20. | Visits doctor with doctor finding nothing wrong | 20 | _____ | _____ | _____ |
| 21. | Has trouble sleeping | 21 | _____ | _____ | _____ |
| 22. | Worries a lot | 22 | _____ | _____ | _____ |
| 23. | Wants to be with you more than before | 23 | _____ | _____ | _____ |
| 24. | Feels he or she is bad | 24 | _____ | _____ | _____ |
| 25. | Takes unnecessary risks | 25 | _____ | _____ | _____ |
| 26. | Gets hurt frequently | 26 | _____ | _____ | _____ |
| 27. | Seems to be having less fun | 27 | _____ | _____ | _____ |
| 28. | Acts younger than children his or her age | 28 | _____ | _____ | _____ |
| 29. | Does not listen to rules | 29 | _____ | _____ | _____ |
| 30. | Does not show feelings | 30 | _____ | _____ | _____ |
| 31. | Does not understand other people's feelings | 31 | _____ | _____ | _____ |
| 32. | Teases others | 32 | _____ | _____ | _____ |
| 33. | Blames others for his or her troubles | 33 | _____ | _____ | _____ |
| 34. | Takes things that do not belong to him or her | 34 | _____ | _____ | _____ |
| 35. | Refuses to share | 35 | _____ | _____ | _____ |

Total score _____

Does your child have any emotional or behavioral problems for which she/he needs help? ( ) N ( ) Y
Are there any services that you would like your child to receive for these problems? ( ) N ( ) Y

If yes, what services?_____

**Pediatric Symptom Checklist - Youth Report (Y-PSC)**

Please mark under the heading that best fits you:

| | Never | Sometimes | Often |
|---|---|---|---|
| 1. Complain of aches or pains..... | ___ | ___ | ___ |
| 2. Spend more time alone..... | __ | ___ | ___ |
| 3. Tire easily, little energy..... | ___ | ___ | ___ |
| 4. Fidgety, unable to sit still..... | ___ | ___ | ___ |
| 5. Have trouble with teacher…… | ___ | ___ | ___ |
| 6. Less interested in school..…….. | ___ | ___ | ___ |
| 7. Act as if driven by motor..... | ___ | ___ | ___ |
| 8. Daydream too much..... | ___ | ___ | ___ |
| 9. Distract easily..... | ___ | ___ | ___ |
| 10. Are afraid of new situations..... | ___ | ___ | ___ |
| 11. Feel sad, unhappy..... | ___ | ___ | ___ |
| 12. Are irritable, angry..... | ___ | ___ | ___ |
| 13. Feel hopeless..... | ___ | ___ | ___ |
| 14. Have trouble concentrating..... | ___ | ___ | ___ |
| 15. Less interested in friends..... | ___ | ___ | ___ |
| 16. Fight with other children..... | ___ | ___ | ___ |
| 17. Absent from school. ……. | ___ | ___ | ___ |
| 18. School grades dropping. …….. | ___ | ___ | ___ |
| 19. Down on yourself..... | ___ | ___ | ___ |
| 20. Visit doctor with doctor finding nothing wrong..... | ___ | ___ | ___ |
| 21. Have trouble sleeping..... | ___ | ___ | ___ |
| 22. Worry a lot..... | ___ | ___ | ___ |
| 23. Want to be with parent more than before..... | ___ | ___ | ___ |
| 24. Feel that you are bad..... | ___ | ___ | ___ |
| 25. Take unnecessary risks..... | ___ | ___ | ___ |
| 26. Get hurt frequently..... | ___ | ___ | ___ |
| 27. Seem to be having less fun..... | ___ | ___ | ___ |
| 28. Act younger than children your age..... | ___ | ___ | ___ |
| 29. Do not listen to rules..... | ___ | ___ | ___ |
| 30. Do not show feelings..... | ___ | ___ | ___ |
| 31. Do not understand other people's feelings..... | ___ | ___ | ___ |
| 32. Tease others..... | ___ | ___ | ___ |
| 33. Blame others for your troubles..... | ___ | ___ | ___ |
| 34. Take things that do not belong to you..... | ___ | ___ | ___ |
| 35. Refuse to share..... | ___ | ___ | ___ |