Lamb Behavioral Health Center, LLC

Gordon D. Lamb, PhD
Licensed Psychologist, TX #35146
info@LambBHC.com

1737 Briarcrest Dr., Suite 24
Bryan, TX 77802
979-436-1956
lambbehavioralhealthcenter.com

Client Background Information

Complete each item in the space to the right of the question. If an item does not pertain to the client, mark *N/A*. If a parent/guardian is completing the form for the client, please respond from the client's perspective. If additional space is needed, attach additional pages or use the back.

Client's name			
Age		Primary language	
Date of birth		Other languages	

Developmental History ***(List details about own early development to best of knowledge)***

Doctor seen during pregnancy?		Method of delivery	
# weeks gestation at delivery		Condition at birth	
Describe complications during pregnancy			
Describe complications during delivery			
Describe prior and/or current speech problems			
Describe prior and/or current problems with motor ability			
Write the approximate age each milestone was reached			
Crawl		First words	
Walk		Speak in sentences	
Ride a bike		Throw a ball	

Medical History

Primary physician		Date of last visit to doctor	
Current medical conditions			
Current medications			
Describe side effects of current medication			
Describe allergies			
Describe vision problems		Describe hearing problems	
Describe any major illnesses, accidents, or other medical issues			
List issues in family medical history			
List issues in family mental health history			

Educational History

Current grade level or highest grade attained		Current teacher (homeroom)	
Current or most recent school attended		Length of time at current school	
Previous schools (name, location)			
Easiest subject		Hardest subject	
Favorite part of school			
Least favorite part of school			
Electives or extra-curricular activities			
Special education (SPED) eligibility		Current SPED services	
Describe significant events in educational history			
Describe feelings toward school			

Family Composition

Family member/ Age	Relation to client	Lives with client Y or N	Daytime activity
Describe current home			
Describe enjoyable family activities			
Describe difficulties in the Family			
Describe major life changes (e.g., moves, deaths, changes in family structure)			

Prior Psychological Services

	Name of provider	Date & length of service	Details of service
Prior psychological or educational testing			
Prior counseling or therapy received			
Other psychological services received			

Emotions and Behaviors ***(If not applicable, please mark "N/A")***

Describe behavioral symptoms	
Frequency	
Duration	
Intensity	
Describe current emotional symptoms	
Describe eating problems	
Describe sleeping difficulties	
Describe prior or current drug use	
Describe encounters with law enforcement	
Describe desires to harm self or others	
Describe visual or auditory hallucinations	