Aviva Bass-Huh, Psy.D.
Licensed Clinical Psychologist
(720)938-3423

NEW CLIENT INFORMATION SHEET-CHILD

Completing this form may save us some time in our therapy session. However, all of the information requested is completely voluntary. Leave blank any item you do not wish to answer.

Name of Client:_____

Date of Birth: _____ Age: ___ M/F

Address: _____
Street Address

_____
City State Zip Code

Name of Person Completing this Form: _____ Relationship to Client:_____

Parents/Legal Guardians

Name: _____ Relationship: _____

Phone: _____ Voice mail ok? y/n Text message ok? y/n

Name: _____ Relationship: _____

Phone: _____ Voice mail ok? y/n Text message ok? y/n

Parents' Marital Status: ___ married
___ single, never married
___ divorced/separated
___ mother deceased
___ father deceased
___ mother remarried
___ father remarried

List all people living in the home:

Name	Age	Relationship to child
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List any other people who care for the child a significant amount of time:

Name	Relationship to child (e.g., grandparent, nanny etc.)
_____	_____
_____	_____

Current school: _____ Current Grade: ____

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Was child adopted? ___ Yes ___ No If yes, age when adopted: ____

How many caffeinated beverages does your child have on average per day? _____

What time is the child in bed with lights out on school nights? _____

What time does the child wake up on school mornings? _____

Does the child often wake up in the middle of the night? ____ Yes ____ No

If yes, how often and for how long? _____

Please list any past or current mental health services received in the space below:

Therapist/Doctor	Dates	Reason for treatment

Any current medical conditions being treated? _____

_____

Current medications (prescription, over the counter, and herbal remedies; name & dose):

_____

_____

Approximate date of last physical examination: _____