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

NEW CLIENT INFORMATION SHEET-ADOLESCENT

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

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

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 your home:

Name	Age	Relationship to client (e.g., sister etc.)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List any other adults who are involved in your life a significant amount of time.

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

TURN PAGE OVER

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Current school: _____ Current Grade: ____

Were you adopted? ___ Yes ___ No If yes, age when adopted: ____

How many caffeinated beverages do you have on average per day? _____

What time are you in bed with lights out on school nights? _____

What time do you wake up on school mornings? _____

Do you 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: _____