

Catherine M. Malkin, Ph.D., LLC  
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**CLIENT INFORMATION: Child and Teen**

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Pronouns: \_\_\_\_\_ Gender as given to insurance co: \_\_\_\_\_

Home Address: \_\_\_\_\_  
\_\_\_\_\_

Parent's Name: \_\_\_\_\_ Spouse/Partner's Name: \_\_\_\_\_

Parent's Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Parent's Employer: \_\_\_\_\_ Work #: \_\_\_\_\_ Home/cell: \_\_\_\_\_

Parent's Name: \_\_\_\_\_ Spouse/Partner's Name: \_\_\_\_\_

Parent's Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Parent's Employer: \_\_\_\_\_ Work #: \_\_\_\_\_ Home/cell: \_\_\_\_\_

Please indicate the telephone number you wish me to use to contact you

Emergency Contact: Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to client: \_\_\_\_\_

Any medications, including doses and any supplements or vitamins: \_\_\_\_\_  
\_\_\_\_\_

Any known allergies: \_\_\_\_\_

Brief description of why you are seeking therapy for your child/teen: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other pertinent information: \_\_\_\_\_  
\_\_\_\_\_

If parents are divorced or separated, please bring a copy of custody papers to the first appointment.