Catherine M. Malkin, Ph.D., LLC
6797 N. High St., Suite 214 Worthington, OH 43085
Ph: 614-505-6949 Fax: 614-505-6558
www.catherinemalkinpsychologist.com

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.