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YOUTH CLIENT INFORMATION FORM

Youth Full Name: _____ Social Security #: _____
Date of Birth: ____/____/____ Age: _____ Gender: _____
Home Address: _____ Apt: _____
City: _____ State: _____ Zip: _____
Phone number: _(_____) _____ ☐Home ☐Cell Safe to Leave Message? ☐Yes ☐No
Phone number: _(_____) _____ ☐Home ☐Cell Safe to Leave Message? ☐Yes ☐No

Parent/Caregiver Information

Full Name: _____ Relationship to youth: _____
Date of Birth: ____/____/____ Age: _____ Gender: _____ Social Security #: _____
Home Address: _____ Apt: _____
City: _____ State: _____ Zip: _____
Phone number: _(_____) _____ ☐Home ☐Cell Safe to Leave Message? ☐Yes ☐No
Phone number: _(_____) _____ ☐Home ☐Cell Safe to Leave Message? ☐Yes ☐No
E-mail address: _____ Okay to E-mail? ☐
Does this parent/caregiver have parental rights over the youth listed above? ☐Yes ☐No

Full Name: _____ Relationship to youth: _____
Date of Birth: ____/____/____ Age: _____ Gender: _____ Social Security #: _____
Home Address: _____ Apt: _____
City: _____ State: _____ Zip: _____
Phone number: _(_____) _____ ☐Home ☐Cell Safe to Leave Message? ☐Yes ☐No
Phone number: _(_____) _____ ☐Home ☐Cell Safe to Leave Message? ☐Yes ☐No
E-mail address: _____ Okay to E-mail? ☐
Does this parent/caregiver have parental rights over the youth listed above? ☐Yes ☐No

(please use back side to list additional parents/caregivers, if needed)

Emergency Contact - If some kind of emergency arises and we cannot reach one of the listed parents/caregivers directly, whom should we call?

Name: _____ Relationship to youth: _____
Address: _____ Phone: _(_____)_____
_____ E-mail: _____

Medical Information

Current Medications Youth is Taking:

Name of Medication	Dose	What is this medication for?
_____	_____	_____
_____	_____	_____
_____	_____	_____

(please use back side to list additional medications, if needed)

If the youth is currently working with a psychiatrist and/or primary care physician who is prescribing medications to them for psychological reasons, please fill out the following information (if known):

Doctor's Name: _____ Practice/Company Name: _____
Address: _____ Phone: _(_____)_____
_____ Fax: _(_____)_____
E-mail: _____

Please note, the youth's doctor(s) will not be contacted without your approval via a signed Consent to Release Information Form, which can be found at <http://insightpsychologicalservices.org/forms/>

Has the youth ever been hospitalized for psychiatric/psychological reasons? ☐Yes ☐No

If yes, please use the space below to indicate what the specific reason for hospitalization was, where they were hospitalized, and when. You may also choose to speak directly with us on this matter if you wish.

What other medical information regarding the youth would you like to share with us? (e.g., hospitalizations, surgeries, past medications, past/present diagnoses, developmental delays, etc.)

Educational Information

School: _____ Grade: _____

City: _____ State: _____

What are the youth's typical grades?

Is the youth currently experiencing any known difficulties in school?

Is the youth currently on an IEP? ☐Yes ☐No If yes, what is the IEP for?

Treatment Information

Please tell us a little bit about what led to the youth coming in to see us for therapy? Do you have specific goals in mind or topics that you would like to be addressed in therapy? What would you like for them to get out of therapy?

Has the youth ever been in therapy before? ☐Yes ☐No

If yes, please fill out the following information (if known):

Dates Seen	Name of Therapist/Psychologist	Reason for Therapy
___/___ to ___/___	_____	_____
___/___ to ___/___	_____	_____
___/___ to ___/___	_____	_____

(please use back side to list additional therapists/psychologists, if needed)

If the youth has been to therapy before, what do you think was most helpful about past treatment providers' approaches?

Please use the space below to tell us anything else that you think would be important for us to know prior to beginning therapy with the youth: