NEW HORIZONS
THERAPY SERVICES

Nicole D. Gehl
B.A., PG Dip CBTcyp, M.A., J.D., Adv.Dip.Ex.Psych.,
BABCP, UKCP, MBACP (Accred)

Suite 16
Tel: 0781 206 0867

58 Acacia Road
St John's Wood
London NW8 6AG

E-Mail: NDGehl@gmail.com

Client Information Form (CYP)

FULL NAME: _____ DOB:_____

ADDRESS: _____

_____

GENDER:(M) ☐ (F) ☐ (prefer not to say) ☐

MEDICAL DIAGNOSIS (if any)_____

PREVIOUS PSYCHOLOGICAL THERAPY:_____

PARENTAL HISTORY OF MENTAL HEALTH PROBLEMS:

_____

MOTHER/GUARDIAN: _____ AGE: _____

FATHER/GUARDIAN: _____ AGE: _____

HOME ADDRESS: _____

HOME PHONE: _____

MOBILE:_____

EMAIL ADDRESS: _____

PLEASE LIST ANY SIBLINGS: (Name and Age) _____

_____

GP NAME:_____TELEPHONE:_____

ADDRESS:_____

E**DUCATIONAL/SOCIAL HISTORY**

1. Please list the names of any schools or other agencies or programs in which your child is or has been involved, describing his/her general performance.

_____

_____

_____

2. What year is your child in at school? _____

3. Please describe any special help your child receives at home/school. TYPE OF HELP, HOW OFTEN, FROM WHOM

_____

_____

_____

_____

4. Has your child received any assessments?

_____

Do you have the results? _____If so, please send them to me. Do you know which tests were administered and what were your child's scores?

_____

_____

_____

5. In your words, please describe your child’s personality and behaviour.

_____

_____

_____

_____

6. In your words, please describe your concerns about your child's difficulties:

_____

_____

_____

_____

_____

_____

LAST VISIT TO GP?_____MOTIVE FOR LAST VISIT:_____