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NEW CLIENT QUESTIONNAIRE

Name: ____ Today's Date: __________________________________

Date of Birth: ___________________ Age: ___________ Gender: ____ Sexual Orientation: __________________

Occupation: ____________________________________ Race/Ethnicity: __________________________________

Social Security No: ______________________________ Religion: ______________________________________

Address: ______________________________________ Referred by: ___________________________________

____ May I acknowledge referral: Y N

Home Phone: ___________________________________ Okay to leave messages? Y N

Work Phone: ___________________________________ Okay to leave messages? Y N

Cell Phone: ____________________________________ Okay to leave messages? Y N

E-mail: ____ Okay to e-mail you? Y N

Emergency Contact Name: _________________________ Phone Number: _____________________________

Relationship to Emergency Contact: ________________ Marital Status: ______ Years in Relationship: ___

Current Partner/Spouse's name: __________________ Age: ____ Occupation: ______________________

MEDICAL INFORMATION:

Current Physician: ______________________________ Phone: __________________ Last exam: ______________

Do you have any medical diagnoses or concerns? Y N
If yes, please list:

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Current Medications	Dose	Purpose

MENTAL HEALTH INFORMATION:

Are you currently receiving psychiatric or mental health services elsewhere? Y N

Current Mental Health Providers:

Provider Name	Contact Information	Dates of treatment	Purpose of Treatment

Previous Mental Health Providers:

Provider Name	Contact Information	Dates of treatment	Purpose of Treatment

Please list three things that are important to you in your life:

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Bellow you will find a list of common challenges people face. Please check any that apply to you at present. Circle the three that bother you most at this point in time.

Anxiety
___ Generalized Anxiety ___ Specific fears/phobias ___ Panic attacks ___ Social Anxiety
___ Obsessive thinking ___ Compulsive behaviors

Mood
___ Sadness or Depression ___ Anger or Irritability ___ Loss of pleasure in life ___ Frequent crying
___ Mania ___ Loss of energy ___ Emotionally overwhelmed
___ Thoughts of suicide ___ Mood Swings

Behaviors
___ Self-harm behavior (cutting/burning/scratching self)
___ Problems with eating
___ Body-focused repetitive behaviors (skin picking, hair pulling, nail biting, etc.)

Sleep
___ Problems falling asleep ___ Trouble waking up ___ Fatigue/tiredness during the day
___ Problems sleeping through the night ___ Nightmares

Cognitive
___ Problems with attention or concentration ___ Racing thoughts ___ Paranoia
___ Memory Problems

Interpersonal
___ Problems making or keeping relationships ___ Relationship/Marriage problems
___ Problems with intimacy ___ Sexual problems
___ Shyness ___ Family Problems
___ Recent Breakup/Separation/Divorce ___ Difficulties with Assertiveness

Identity
___ Sexuality ___ Self-esteem ___ Sense of self ___ Cultural concerns
___ Career choices ___ Personal values ___ Body image concerns

Other
___ History of abuse (emotional, physical, sexual) ___ Problems with job/school
___ Problems with Alcohol or Drugs ___ Financial problems ___ Legal situation
___ Grief or Loss ___ Traumatic experience ___ Medical Problems
___ Racism/ discrimination ___ Other: ____

If there is anything else you would like Dr. Levoy to know or ask about, please briefly describe here:

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Thank you for taking the time to complete this form!