Fresh Start Therapy & Coaching
Dr. Ruxandra LeMay

New Client Questionnaire

Name: ______________________________ Age: _______________________

Preferred Phone:_____________________________ May I leave a VM? □Yes □No
Text? □Yes □No

Address:____

Email: ______________________________________ May I email you? □Yes □No
Do you prefer regular email □Yes □No
or client portal communication (secure/password protected) □Yes □No

Emergency Contact (name, relationship, phone):

____

Referred by/how did you find me?______________________________________

Have you previously received any type of mental health services (psychotherapy, psychiatric help, counseling, self-help, etc.)? □ No □ Yes

Are you currently employed or in school? □ No □ Yes What is your current occupation?
____

What is your highest level of formal education?_______________________________

Relationship Status:
□ Single □ Cohabitating/Domestic Partnership □ Married □ Separated □ Divorced
□ Widowed

Any children/ages:____

Have you had or do you currently have any legal issues? □ No □ Yes

Please circle and rate:

Current physical health	Poor	Satisfactory	Great
Sleep quality	Poor	Satisfactory	Great
Appetite or eating patterns	Poor	Satisfactory	Great
Exercise or physical activity level	Poor	Satisfactory	Great

Have you had or are you currently having thoughts of harming yourself or others?

□ No □ Yes If yes, describe:____

Have you had any suicide attempts? □ No □ Yes: If yes, describe circumstances/dates:

____

Are you currently taking any medication including psychiatric meds? □ No □ Yes Pease list medication(s) & who's prescribing it:

____

____

Symptom Checklist

In the section below identify if you are experiencing any of the following or if there is a family history to the best of your knowledge. Please check yes or no, and list Family Member if applicable (mother, father, sister, brother, uncle, etc.)

Alcohol/Substance Abuse □ No □ Yes Family History__________________

Anxiety/Fear □ No □ Yes Family History__________________

ADHD □ No □ Yes Family History__________________

Depression □ No □ Yes Family History__________________

Domestic Violence/Abuse □ No □ Yes Family History__________________

Eating Disorders □ No □ Yes Family History__________________

Schizophrenia □ No □ Yes Family History__________________

Obsessive Compulsive Behaviors □ No □ Yes Family History__________________

Bi-Polar Disorder □ No □ Yes Family History__________________

Relationship Issues/Divorce □ No □ Yes Family History__________________

Sexual Issues □ No □ Yes Family History__________________

Chronic Pain/Disability □ No □ Yes Family History__________________

Other Addictions □ No □ Yes Family History__________________

Grief/Loss/Trauma □ No □ Yes Family History__________________

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Have you ever tried the following? (check all that apply)

- ☐ Alcohol
- ☐ Tobacco
- ☐ Marijuana
- ☐ Hallucinogens
- ☐ Heroin
- ☐ Methamphetamines
- ☐ Cocaine
- ☐ Stimulants (pills)
- ☐ Ecstasy
- ☐ Methadone
- ☐ Tranquilizers
- ☐ Pain killers
- ☐ Sleeping medication

If yes to any, list frequency and general dates of use:

____
____
____
____
____

Describe Main Reason for today's appointment:

____
____
____
____
____
____
____
____
____
____

Anything else you'd like me to know that has not been covered?

____
____
____

Preferred therapeutic style:

- ☐ Straight to the point
- ☐ Eases me into the problem and solution
- ☐ Emotion focused, helps me process, understand and express my emotions
- ☐ Stays away from too much emotion stuff, focuses on thoughts and actions
- ☐ Solution focused
- ☐ Gives me the solutions
- ☐ Helps me find my own solutions
- ☐ Gives me as much info needed as possible in a short period of time
- ☐ Takes it easy and doesn't overwhelm me with too much

Other preferred methods of consuming self-care and psychoeducation materials:

- ☐ You Tube videos
- ☐ Blogs
- ☐ Books
- ☐ Online courses
- ☐ Pinterest

Signature____________________ Date______________________________