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Client Information Sheet

Name: _____ Age: _____

Address: _____

Phone Numbers:

Daytime: _____ Is it okay to leave messages? Y or N

Evening: _____ Is it okay to leave messages? Y or N

Cell/Pager: _____ Is it okay to leave messages? Y or N

Education: _____ Occupation: _____

Employed by: _____ How long? _____

Family Physician: _____ Consent to Contact: _____

In case of emergency, whom shall I contact?

Name: _____

Phone Number: _____

May I thank the person who gave you my name? Y or N

Name: _____

Address: _____

Phone Number: _____

What brings you to therapy today?

Have you ever been in therapy before? (if yes, describe when, how long, and why)

Are you currently taking any medication or are you under any other type of treatment?

Describe briefly your current family or primary relationship.

Name	Age	Relationship	How do you get along?
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Have you ever harmed yourself? _____

Have you ever harmed others? _____