Nicole Brulé, PsyD
Licensed Psychologist
(541) 953-3929

Today's Date:_____

Name:_____

Date of Birth:_____ _____Male _____Female

Social Security #_____ email address: _____

Race or ethnicity: _____ Marital Status: _____

Address:_____ City:_____ State:_____

Zip:_____

(Please provide all numbers that apply, but check which number you prefer I use)

___Day Phone: (_____)_____ Ok to leave a message _____Yes _____No

___Evening Phone: (_____)_____ Ok to leave a message _____Yes _____No

___Cell Phone: (_____)_____ Ok to leave a message _____Yes _____No

Emergency Contact:_____

Relationship:_____

Emergency Contact Phone: (_____)_____

Name of Insurance Company: _____

Name of Policy Holder: _____

Date of Birth:_____

Address:_____

Employer:_____

Referred by/ Referral source: _____

What brings you in? Please describe your reasons for seeking therapy at this time?

What are your goals for our work together? What would you like to be different after you have been in therapy?

What do you see might possibly get in the way of you resolving your current problems or achieving your goals?

What do you see as your strengths that might help you in making any desired changes?

Have you received previous counseling or substance abuse treatment (please circle)? Yes_____ no_____
If yes, how was this experience for you? _____

Are you currently seeing anyone else for mental health conditions? If so, who?

Are you taking any medications (include dose)? _____
Who prescribes them? _____

Name of current primary care doctor: _____

Personal and Family Background Information

Parents currently are: married/ live together_____ separated_____ divorced_____ never lived together_____ one or both deceased_____

Please list all family members below include their relationship to you and their age (if deceased put age deceased)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Please check all that apply:

Family history of:

____ Counseling

____ Depression

____ Anxiety

____ Eating Disorders

____ Sex Abuse/ or Incest

____ Interpersonal violence

____ Alcohol Dependence

____ Drug dependence

____ Chronic mental illness

____ Chronic physical illness

____ Psychiatric hospitalization

____ Suicide Attempts/ Completion

Please check all that apply:
I use alcohol: never__ less than once/ week__ more than once /week___ daily___
I use drugs: never__ less than once/ week__ more than once /week___ daily___
I use tobacco: never__ less than once/ week__ more than once /week___ daily___
I have experienced an unwanted sexual experience: recently___ in the past___
sexual assault___ date rape__ rape__ incest___
My sleep is: _____ hours a night / Frequent waking? ___/ Difficulty falling asleep? ___ Staying asleep? ___
I am dissatisfied with my personal appearance _____
I have felt like or tried to hurt myself in the past_____ and/ or _____currently
I have suffered a significant loss/ death _____relationship ending _____ other_____
I have experienced:
___ medical complications at birth
___ serious head injury (or knocked out)

___ past learning disability or attention deficit/ hyperactivity disorder
___ permanent disability (if checked please describe:_____)
___ legal difficulties (if checked please describe:_____)

Adult Wellbeing

Today's Date: _____ Name:_____Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Feeling nervous, anxious, or on edge	0	1	2	3
4. Not being able to stop or control worrying	0	1	2	3

Has there ever been a period of time when you were not your usual self and...	No	Yes
5. ... you felt so good or full of energy that other people thought you were not your normal self or it got you into trouble? (e.g., unable to sleep, over-spending, gambling)	☐	☐
6. ...you were so irritable that you shouted at people or started fights or arguments?	☐	☐

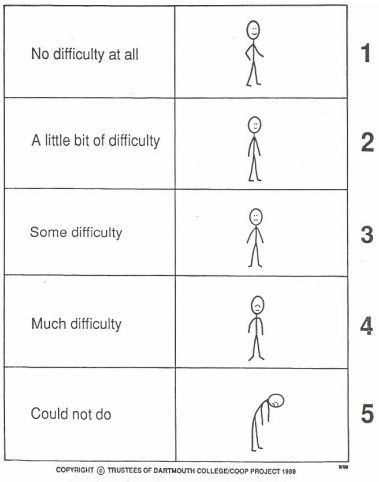
During the past year:	No	Yes
7. Have you had 4 or more drinks (women) / 5 or more drinks (men) in a day?	☐	☐
8. Have you used an illegal drug or used a prescription drug for a non-medical reason?	☐	☐

Over the last 4 weeks:	No	Yes
9. Have you had a problem with sleep more than occasionally? (This could include: trouble falling asleep, waking frequently, or sleeping too much.)	☐	☐

10. **Circle the number or description that most accurately describes your daily activities, social activities and overall health in the past 4 weeks.**

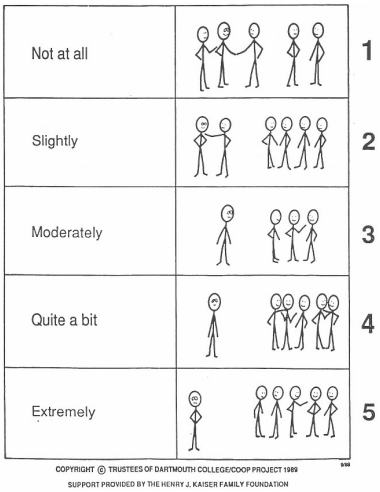
DAILY ACTIVITIES

How much difficulty have you had doing your usual activities or task, both inside and outside the house because of your physical and emotional health?



SOCIAL ACTIVITIES

Has your physical and emotional health limited your social activities with family, friends, neighbors, or groups?



OVERALL HEALTH

How would you rate your health in general?