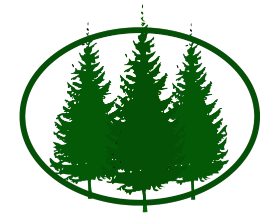
Brulé Counseling, LLC

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



David Brulé, PhD
Licensed Psychologist
(541) 623-0679

Date:____________________

Name:____ Date of Birth:_____________________

Gender: ☐ Male, ☐ Female, Other:___________________ Social Security #:___________________

Race or ethnicity: ___________________________________ Relationship Status:_________________

Address:____

City:______________________________________ State:_____________ Zip:____________

Email address: ____

Phone number(s): (please provide all numbers that apply and check which number you prefer I use)

☐ Cell Phone: (_______)_______________________, Ok to leave a message? ☐ Yes ☐ No

☐ Home Phone: (_______)______________________, Ok to leave a message? ☐ Yes ☐ No

☐ Day Phone: (_______)_______________________, Ok to leave a message? ☐ Yes ☐ No

☐ Eve. Phone: (_______)_______________________, Ok to leave a message? ☐ Yes ☐ No

Emergency Contact:____

Relationship:____

Phone #: (________)________________________

Name of primary care doctor: ____

Phone #: (________)________________________

Insurance Company: ____

Policy holder's name:____

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 therapy?

____
____
____
____
____

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

What do you see as your strengths that could help you make 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? ____

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?

No difficulty at all	1
A little bit of difficulty	2
Some difficulty	3
Much difficulty	4
Could not do	5

SOCIAL ACTIVITIES

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

Not at all	1
Slightly	2
Moderately	3
Quite a bit	4
Extremely	5

OVERALL HEALTH

How would you rate your health in general?

Excellent	1
Very good	2
Good	3
Fair	4
Poor	5