

# Brulé Counseling, LLC

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Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

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

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

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What do you see as your strengths that could help you make any desired changes?

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Have you received previous counseling or substance abuse treatment (please circle)? Yes \_\_\_\_\_ no \_\_\_\_\_  
If yes, how was this experience for you?

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

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Are you taking any medications (include dose)?

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Who prescribes them? \_\_\_\_\_

Do you or have you had any major medical conditions? If so what are they:

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In your childhood did you reach all developmental milestones on time or within a normal range? If not please briefly explain.

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Have you ever had any legal issues? If so please briefly explain:

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Are you currently employed? or are you a student? Briefly describe your work or focus and stage of schooling:

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# 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: (please also indicate who in the family struggled with these things)

- |   |   |
|---|---|
| <input type="checkbox"/> Counseling             | <input type="checkbox"/> Alcohol Dependence           |
| <input type="checkbox"/> Depression             | <input type="checkbox"/> Drug dependence              |
| <input type="checkbox"/> Anxiety                | <input type="checkbox"/> Chronic mental illness       |
| <input type="checkbox"/> Eating Disorders       | <input type="checkbox"/> Chronic physical illness     |
| <input type="checkbox"/> Sex Abuse/ or Incest   | <input type="checkbox"/> Psychiatric hospitalization  |
| <input type="checkbox"/> Interpersonal violence | <input type="checkbox"/> 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: \_\_\_\_\_)

# 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)	<input type="checkbox"/>	<input type="checkbox"/>
6. ...you were so irritable that you shouted at people or started fights or arguments?	<input type="checkbox"/>	<input type="checkbox"/>






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

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.)	<input type="checkbox"/>	<input type="checkbox"/>

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

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### SOCIAL ACTIVITIES






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

No: at all		1
Slightly		2
Moderately		3
Quite a bit		4
Extremely		5

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### OVERALL HEALTH

How would you rate your health in general?

Excellent		1
Very good		2
Good		3
Fair		4
Poor		5

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