Katherine Bruss, Psy.D.
1244 Clairmont Road
Decatur, GA 30030
678-459-5447

Client Information Form

This form is completely confidential

Today's date: _____

Name: _____
Last **First** **Middle Initial**

Date of Birth: _____ Name of Insurance Plan_____

Insurance Member ID: _____Name of Insured:_____

Home Street Address: _____

City: _____ State: _____Zip:_____

Home Phone: _____ Work Phone: _____
Ok to leave message? Y/N? **Ok to leave message? Y/N?**

Cell Phone: _____ Email: _____
Ok to leave message? Y/N? **Ok to send message? Y/N?**

Preferred number to call (list any restrictions):_____

Referred by: _____

- May I have your permission to thank this person for the referral?
  Yes No
- If referred by another clinician, would you like for us to communicate with one another?
  Yes No

Person(s) to notify in case of any emergency: _____
Name **Phone #**

I will only contact this person if I believe it is a life or death emergency. Please provide your signature to indicate that I may do so: (Your Signature): _____

Please briefly describe your presenting concern(s): _____
_____
_____
_____
_____

What are your goals for therapy? _____
_____
_____
_____
_____

How long do you expect to be in therapy in order to accomplish these goals (or at least feel like you have the tools to accomplish them on your own)? _____
_____

The following information on this form will help guide your treatment. Please try to fill out as much as you are comfortable disclosing.

MEDICAL HISTORY:

Please explain any significant medical problems, symptoms, or illnesses: _____
_____
_____

Current Medications:

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

Do you smoke or use tobacco? YES NO If YES, how much per day?_____
Do you consume caffeine? YES NO If YES, how much per day? _____
Do you drink alcohol? YES NO If YES, how much per day/week/month? _____
Do you use any non-prescription drugs? YES NO
If YES, what kinds and how often? _____
Have any of your friends or family members voiced concern about your substance use? YES NO
Have you ever been in trouble or in risky situations because of your substance use? YES NO
Name of primary care physician and date of last physical exam:_____
_____
Previous medical hospitalizations (Approximate dates and reasons):_____
_____
_____
Previous psychiatric hospitalizations (Approximate dates and reasons):_____
_____
Have you ever talked with a psychiatrist, psychologist, or other mental health professional? YES NO
(Please list approximate dates and reasons): _____
_____
_____
Height _____ Weight _____ Age_____ Gender _____
Sexual Identity: Heterosexual__ Lesbian__ Gay__ Bisexual__ In Question__

FAMILY:

How would you describe your relationship with your mother?_____
_____
_____
How would you describe your relationship with your father?_____
_____
_____
Are your parents still married?_____ If they divorced, how old were you when they separated or divorced, and how did this impact you? _____
_____
Were there any other primary care givers who you had a significant relationship with? If so, please describe how this person may have impacted your life: _____
_____
How many sisters do you have? _____ Ages? _____
How many brothers do you have? _____ Ages? _____
How would you describe your relationships with your siblings? _____

RELATIONSHIPS & SOCIAL SUPPORT

Currently in Relationship? ____ How Long? ____ Relationship Satisfaction: POOR 1 2 3 4 5 6 7 EXCELLENT

Married/Life Partnered? _____ How Long? ____ Previously Married/Life Partnered? YES NO
If so, # and length of previous marriages/committed partnerships_____

Do you have Children?____ If YES, how many and what are their ages:_____

List the names and ages of those living in your household: _____
_____

Describe any problems any of your children are having: _____
_____

Please briefly describe any history of abuse, neglect and/or trauma: _____
_____
_____

Current level of satisfaction with your friends and social support: POOR 1 2 3 4 5 6 7 EXCELLENT

SELF-CARE & COPING SKILLS:

Please indicate the degree to which you engage in the following on a scale from 1-5:

1=Never 2=Rarely 3=Occasionally 4=Often 5=Always

___1. Aerobic exercise (aerobics, running, biking, etc.)
___2. Anaerobic exercise (strength, weight training)
___3. Maintain a healthy diet
___4. Use relaxation techniques
___5. Talk with family or friends
___6. Ignore the problem
___7. Interact with your pet
___8. Focus more on other projects (school, work, etc.)
___9. Read books
___10. Use food as a comfort or distraction
___11. Worry about the problem
___12. Seek religious or spiritual help (prayer, meditation, talk with religious leader)
___13. Seek professional help (counselor, physician, dietician, etc.
___14. Other_____

What do you think are your strengths?_____
_____

EDUCATION & CAREER

High School/GED___ College Degree___ Graduate Degree(Masters___Doctoral___) Vocational Degree___

Name of Employer:_____

What is your profession/current job title?_____

Employment Satisfaction: POOR 1 2 3 4 5 6 7 EXCELLENT

Any past career positions that you feel are relevant?_____
_____

PLEASE CHECK ALL THAT APPLY & ***CIRCLE*** THE MAIN PROBLEM:

DIFFICULTY WITH:	NOW	PAST		DIFFICULTY WITH:	NOW	PAST		DIFFICULTY WITH:	NOW	PAST
Anxiety →				Social isolation →				Pain →		
Sadness				Parents				Abdominal Distress		
Mood Changes				Children				Chronic Illness		
Anger or Temper				Marriage/Partnership				Dizziness/Fainting		
Panic				Friend(s)				Nausea/Diarrhea		
Fears				Co-Worker(s)				Shortness of Breath		
Irritability				Employer/Career				Chest Pain		
Concentration				Finances				Lump in the Throat		
Headaches				Legal Problems				Sweating		
Loss of Memory				Sexual Assault/Harassment				Heart Palpitations		
Excessive Worry				History of Child Abuse				Muscle Tension		
Feeling Manic				History of Sexual Abuse				Poor Appetite		
Feeling Hopeless				Domestic Violence				Allergies		
Communicating with Others				Thoughts of Hurting Someone Else				Often Make Careless Mistakes		
Trusting Others				Hurting Self				Allergies Fidget Frequently		
Drugs				Thoughts of Suicide				Speak Without Thinking		
Alcohol				Sleeping Too Much/Little				Waiting Your Turn		
Blackouts				Getting to Sleep				Completing Tasks		
Eating Problems				Waking Too Early				Paying Attention		
Severe Weight Gain				Nightmares				Easily Distracted by Noises		
Severe Weight Loss				Sexual Concerns				Chills or Hot Flashes		
Frequent Vomiting				Self-Esteem				Head Injury		

FAMILY HISTORY OF (Check all that apply):

Drug/Alcohol Problems				Physical Abuse				Depression			
Legal Trouble				Sexual Abuse				Anxiety			
Domestic Violence				Hyperactivity				Psychiatric Hospitalization			
Suicide				Learning Disabilities				"Nervous Breakdown"			

Any additional information you would like to include: