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DBT CLIENT INFORMATION SHEET

Name: _____ Date: _____

Address: _____

Phone Numbers: Home _____ OK to leave message? Y N
Cell _____ OK to leave message? Y N
Work _____ OK to leave message? Y N

Email address: _____

Date of Birth: _____ Age: _____

Highest level of education attained? _____

Occupation _____ Place of Employment _____

Religious or Spiritual orientation _____

Referred by: _____

May I contact this person to let him/her know you came for your appointment? Y N

Signature: _____

Medical Information:

Physician's Name _____ Phone Number: _____

Current Medications and dosages:

Please continue on next page

Psychotherapy Information:

Currently in therapy? Y N

Therapist Name: _____ Phone Number: _____

Approximate Date began therapy: _____

Have you been in therapy prior to the above listed therapist? Y N

Therapist Name: _____ Phone Number: _____

Approximate dates Seen: _____

Previous psychiatric or substance abuse hospitalization? Y N

Hospital: _____

Dates: _____

Emergency Contact Information:

Name of Person to contact in case of a medical or psychological emergency:

_____ Relationship: _____

Home phone: _____ Cell phone: _____ Work phone: _____

Note: This person would be contacted only with your consent or under life threatening circumstances according to American Psychological Association standards.