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	EAP/MCO/ HP: Self Pay:

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MENTAL HEALTH HISTORY QUESTIONNAIRE – ADULT

All questions contained in this questionnaire are strictly confidential and will become part of your mental health record. Use back of page if you would like to add any additional information

Name (Last, First, MI):	<input type="checkbox"/> M <input type="checkbox"/> F	DOB:	AGE:
Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Cohabiting <input type="checkbox"/> Life Partner <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed # of Marriages:		
Household	# of children:	Age Range:	Do they live in your home? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Some of the time
Education	Highest Grade: <input type="checkbox"/> High School <input type="checkbox"/> Some College <input type="checkbox"/> Bachelor's <input type="checkbox"/> Masters <input type="checkbox"/> Doctorate <input type="checkbox"/> Post Doctorate		
Occupation	How long have you been at your current job?		
Why are you seeking counseling?	How long has this been a problem?		
Why Now?			

Recent Life Changes	
Recent Losses	

AXIS IV - CURRENT STRESSFUL EVENTS – WITHIN THE LAST 6 MONTH PERIOD: CHECK ALL THAT APPLY

Check all that apply	<input type="checkbox"/> Family Problems <input type="checkbox"/> Social Problems <input type="checkbox"/> Educational / Occupational <input type="checkbox"/> Economic / Housing / Health <input type="checkbox"/> Legal <input type="checkbox"/> Interpersonal <input type="checkbox"/> Life Transitions <input type="checkbox"/> Crime Victim <input type="checkbox"/> Trauma / Abuse <input type="checkbox"/> Substance Abuse / CD
Other Not Listed:	

AXIS III – MEDICAL PROBLEMS

Check any that apply in the past 6 months	<input type="checkbox"/> Cardiovascular <input type="checkbox"/> Seizures <input type="checkbox"/> Cancer <input type="checkbox"/> Stroke <input type="checkbox"/> Diabetes <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Alcoholism / Drugs <input type="checkbox"/> Confusion <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Menstrual Difficulty- PMS <input type="checkbox"/> Body Aches / Chronic Pain <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Auto Immune Related <input type="checkbox"/> Chronic Fatigue <input type="checkbox"/> Other:
Known Allergies	<input type="checkbox"/> None <input type="checkbox"/> Environmental <input type="checkbox"/> Food <input type="checkbox"/> Medication SPECIFY:
Allergic Reaction	
Last Physical Exam	DATE: OVERALL HEALTH: <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Unsure
Primary Care (PCP)	Physician's Name: Phone: ()

PREVIOUS MENTAL HEALTH / HOSPITALIZATION HISTORY

Have you seen a counselor before?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3+	Primary Issue / Problem:	Date last seen:
Have you ever been hospitalized for a psychiatric condition?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3+	If Yes, Diagnosis:	Date of last admission:
Are you currently or have you EVER been treated for substance abuse / dependency?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3+	If Yes, Current Status: <input type="checkbox"/> In Recovery <input type="checkbox"/> Relapsed	Longest Abstinence: Problem Substance:

Are you currently taking a prescribed PSYCHOTROPIC MEDICATION? No Yes **How long?**]

Please specify:

Prescribing Dr's Name: **Phone:**

Other prescribed medications / over-the-counter drugs, (vitamins, inhalers)
List them:

- Head Trauma Seizures Childhood Malnutrition Limited Access to Healthcare Developmental Delays Learning Disabilities Trauma Victim Foster Care Abuse Domestic Violence Child Protective Service s Juvenile Confinement School Expulsion Teen Pregnancy

FAMILY HISTORY OF MENTAL / NERVOUS DISORDERS:

Depression Anxiety Disorders / Panic Disorder Bi Polar (Manic Depressive) Obsessive-Compulsive Disorder Schizophrenia Psychosis
 Substance Abuse / Dependency ADD/ ADHD Personality Disorders Other:

Have you ever tried to harm yourself? No Yes **If Yes, How many times?** **Last time, how long ago?**

Has anyone in your family committed suicide? No Yes **If Yes, Whom?** **When?**

SUBSTANCE USE – PERSONAL INVENTORY

All questions contained in this questionnaire are strictly confidential and will become part of your mental health record. Use back of page if you would like to add any additional information

If you drink alcohol please answer:	Have you ever thought you should Cut Down on your drinking ? <input type="checkbox"/> No <input type="checkbox"/> Yes
Average # of drinks per occasion:	Have people Annoyed you by criticizing your drinking ? <input type="checkbox"/> No <input type="checkbox"/> Yes
Average number of occasions per month:	Have you ever felt bad or Guilty about your drinking ? <input type="checkbox"/> No <input type="checkbox"/> Yes
Have you ever attended an AA meeting? <input type="checkbox"/> No <input type="checkbox"/> Yes	Have you ever had a drink in the morning (Eye Opener) to steady your nerves or get rid of a hangover? <input type="checkbox"/> No <input type="checkbox"/> Yes
OTHER SUBSTANCE USE: Please check all other substances you have used and circle current or past as applicable.	<input type="checkbox"/> Nicotine Current Past <input type="checkbox"/> Cannabis Current Past <input type="checkbox"/> Hallucinogen Current Past <input type="checkbox"/> Opioid Current Past <input type="checkbox"/> Cocaine Current Past <input type="checkbox"/> Amphetamine Current Past <input type="checkbox"/> Sedative-Hypnotic-Anxiolytic Current Past OTHER:

AXIS I: DSM IV-TR MENTAL HEALTH CHECKLIST

Additional Notes

BEHAVIOR SYMPTOM INVENTORY: In the Past 30 days check all that apply to you

- | | | |
|--|--|---|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Low Self-Esteem | <input type="checkbox"/> Poor Concentration |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Feel Tense | <input type="checkbox"/> Can't Make Friends |
| <input type="checkbox"/> Low Energy | <input type="checkbox"/> Feel Panicky | <input type="checkbox"/> Afraid Of People |
| <input type="checkbox"/> No Appetite | <input type="checkbox"/> Fears / Phobias | <input type="checkbox"/> Home Conditions Poor |
| <input type="checkbox"/> Over-Eating | <input type="checkbox"/> Job Problems | <input type="checkbox"/> Unable To Have Fun |
| <input type="checkbox"/> Stomach Distress | <input type="checkbox"/> Depressed | <input type="checkbox"/> Worried / Anxious |
| <input type="checkbox"/> Bowel Disturbances | <input type="checkbox"/> Sexual Problems | <input type="checkbox"/> Guilty Feelings |
| <input type="checkbox"/> Always Feel Tired | <input type="checkbox"/> Take Tranquilizers | <input type="checkbox"/> Can't Make Decisions |
| <input type="checkbox"/> Sleep Disturbance | <input type="checkbox"/> Irritability | <input type="checkbox"/> Over-Ambitious |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Dangerous Drugs | <input type="checkbox"/> Financial Problems |
| <input type="checkbox"/> Unable to Relax | <input type="checkbox"/> Angry Outbursts | <input type="checkbox"/> Increased Alcohol Use |
| <input type="checkbox"/> Recurrent Dreams | <input type="checkbox"/> Unmotivated | <input type="checkbox"/> Obsessive Thoughts |
| <input type="checkbox"/> Nightmares | <input type="checkbox"/> Cutting | <input type="checkbox"/> Can't Keep A Job |
| <input type="checkbox"/> Hallucinations /
Delusions | <input type="checkbox"/> Anorexia/Bulimia
Eating Disorder | <input type="checkbox"/> Trauma / Abuse history |

In the **last 30 days** has there been a period of time (**of 2 weeks or more**) when you were feeling depressed or down **MOST** of the day or nearly every day? YES NO

Have you felt a lot less interested in things or unable to enjoy the things you used to enjoy? (**Was it most of the day nearly every day or at least two weeks?**) YES NO

For **two years or more**, have you been bothered by depressed mood most of the day, more days than not? YES NO

IN THE PAST TWO WEEKS: Have you experienced any of the following?

Please check all that apply:

- | | |
|--|--|
| Pronounced weight loss or weight gain | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Difficulty concentrating/indecisive Sleeping too much or too little | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Recurring thoughts of death, dying | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Hurting yourself Fidgety/Agitated or restless behavior | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Making a plan for suicide | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Taking some action toward suicide | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Feeling slowed down | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Feelings of worthlessness or excessive guilt | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Fatigue or loss of energy | <input type="checkbox"/> YES <input type="checkbox"/> NO |

	MBPD
Have you ever had a time when you were feeling so good, high, excited, or hyper that other people thought you were not your normal self or you were so hyper that you got into trouble. (Did anyone say you were manic?)	<input type="checkbox"/> YES <input type="checkbox"/> NO
Has there been a period of time when you felt so irritable that you shouted at people or started fights/arguments?	<input type="checkbox"/> YES <input type="checkbox"/> NO
	DEL
Have you had any unusual experiences, for example did it ever seem like people were talking about you or taking special notice of you?	<input type="checkbox"/> YES <input type="checkbox"/> NO
What about receiving special messages from people or from the way things were arranged around you, or from the newspaper, radio, or TV?	<input type="checkbox"/> YES <input type="checkbox"/> NO
	SZ
Other than when you were depressed or feeling high, has there been a time when you heard voices, had visions, or saw or smelled things that others couldn't see or smell?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Or did you do something to call attention to yourself like dressing in some odd way or doing something strange?	<input type="checkbox"/> YES <input type="checkbox"/> NO
	SA / ETOH
Was there ever a period in your life when you drank too much?(Has alcohol ever caused you problems?)	<input type="checkbox"/> YES <input type="checkbox"/> NO
Has anyone ever objected to your drinking - or a doctor told you to stop drinking?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Have you gone on the wagon or ever tried to cut down on your drinking?	<input type="checkbox"/> YES <input type="checkbox"/> NO
	SA / D
Have you used any street drugs, or used prescription drugs in an amount or way that wasn't prescribed?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If street drug: Has there ever been a time when you took it at least 10 X'S in a one month period of time?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If prescribed: Did you ever get hooked /dependent?	<input type="checkbox"/> YES <input type="checkbox"/> NO
	PAN
Have you ever had a panic attack, when you felt frightened, anxious, uncomfortable, worried about going crazy or suddenly developed a lot of physical symptoms (e.g., heart-pounding, trembling, dizziness)?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If yes, has the panic attack been followed by persistent concern about having additional attacks, worry about the implications or consequences of the attack, or a significant change in behavior related to the attacks?	<input type="checkbox"/> YES <input type="checkbox"/> NO
	OCD
Have you ever been bothered by thoughts, impulses or images that caused anxiety and kept coming back even when you tried not to have them?	<input type="checkbox"/> YES <input type="checkbox"/> NO
What about awful thoughts, like hurting someone against your will, or being contaminated by germs or dirt?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Was there ever anything that you had to do over and over again and couldn't resist doing, like washing your hands again and again, counting to a certain number or checking something several times to make sure you'd done it right?	<input type="checkbox"/> YES <input type="checkbox"/> NO
	PTSD
Is there a traumatic event or memory that keeps coming back in nightmares, flashbacks or thoughts—that you can't put out of your mind, & which continues to cause you great distress?	<input type="checkbox"/> YES <input type="checkbox"/> NO
	AGR
Have you been afraid of leaving the house alone, being in crowds, standing in line, traveling on buses or trains?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Have you felt any of the following?	Please check all that apply <input type="checkbox"/> YES <input type="checkbox"/> NO
Pounding, racing heart	<input type="checkbox"/> YES <input type="checkbox"/> NO
Chest pain or discomfort	<input type="checkbox"/> YES <input type="checkbox"/> NO
Fear of losing control, going crazy	<input type="checkbox"/> YES <input type="checkbox"/> NO
Sweating	<input type="checkbox"/> YES <input type="checkbox"/> NO
Nausea/abdominal distress	<input type="checkbox"/> YES <input type="checkbox"/> NO
	ANX
Fear of dying	<input type="checkbox"/> YES <input type="checkbox"/> NO
Dizzy, lightheaded or faint	<input type="checkbox"/> YES <input type="checkbox"/> NO
Numbness or tingling sensation	<input type="checkbox"/> YES <input type="checkbox"/> NO
Shortness of breath	<input type="checkbox"/> YES <input type="checkbox"/> NO
Feelings of unreality	<input type="checkbox"/> YES <input type="checkbox"/> NO
chills or hot flushes	<input type="checkbox"/> YES <input type="checkbox"/> NO
Feelings of choking	<input type="checkbox"/> YES <input type="checkbox"/> NO
detached from oneself	<input type="checkbox"/> YES <input type="checkbox"/> NO
	SOC ANX
Is there anything that you were ever afraid of or uncomfortable doing in front of others like speaking, eating or writing	<input type="checkbox"/> YES <input type="checkbox"/> NO

Are there any other things that you have been especially afraid of such as flying, snakes, seeing blood, heights, closed places or certain kinds of animals or insects?	PHB
	<input type="checkbox"/> YES <input type="checkbox"/> NO
Have you experienced any of the following? Check all that apply	GAD
Restlessness or feeling keyed up	<input type="checkbox"/> YES <input type="checkbox"/> NO
Irritability	<input type="checkbox"/> YES <input type="checkbox"/> NO
Being easily fatigued	<input type="checkbox"/> YES <input type="checkbox"/> NO
Muscle tension	<input type="checkbox"/> YES <input type="checkbox"/> NO
Difficulty concentrating or mind going blank	<input type="checkbox"/> YES <input type="checkbox"/> NO
Difficulty sleeping or restless sleep	<input type="checkbox"/> YES <input type="checkbox"/> NO
Over the last several years , have you had to go to the doctor often because you weren't feeling well?	SM / HY
	<input type="checkbox"/> YES <input type="checkbox"/> NO
Have you worried that something was wrong, even when a doctor told you there was nothing the matter?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Have you ever had a time when you weighed much less than other people thought you ought to weigh?	ED/AN
At that time were you afraid that you could become fat?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Have you often had times when your eating was out of control?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Have you ever had symptoms of hyperactivity, impulsivity, or restlessness that has persisted for at least 6 months?	ADD
Have you experienced ongoing difficulty with concentration and an inability to focus on tasks?	<input type="checkbox"/> YES <input type="checkbox"/> NO

Is this counseling court-ordered? NO YES If yes, describe the terms of the order

What are your counseling goals?

What are your strengths?

Please add any additional information that you think might be helpful.

Client Signature / Legal Guardian

Date