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Rv.01.2009

Date:

EAP/MCO/ HP:
Self Pay:

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):*		☐ M ☐ F	**DOB:**	**AGE:**
Marital Status	☐ Single ☐ Married ☐ Cohabitating ☐ Life Partner ☐ Divorced ☐ Widowed **# of Marriages:**			
Household	# of children: Age Range: Do they live in your home? ☐ Yes ☐ No ☐ Some of the time			
Education	Highest Grade: ☐ High School ☐ Some College ☐ Bachelor's ☐ Masters ☐ Doctorate ☐ Post Doctorate			
Occupation	How long have you been at your current job?			
Why are you seeking counseling? **Why Now?**	**How long has this been a problem?**			
Recent Life Changes				
Recent Losses				

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

Check all that apply	☐ Family Problems ☐ Social Problems ☐ Educational / Occupational ☐ Economic / Housing / Health ☐ Legal ☐ Interpersonal ☐ Life Transitions ☐ Crime Victim ☐ Trauma / Abuse ☐ Substance Abuse / CD
Other Not Listed:	

AXIS III – MEDICAL PROBLEMS

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

PREVIOUS MENTAL HEALTH / HOSPITALIZATION HISTORY

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

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

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

☐	Headache	☐	Low Self-Esteem	☐	Poor Concentration
☐	Dizziness	☐	Feel Tense	☐	Can't Make Friends
☐	Low Energy	☐	Feel Panicky	☐	Afraid Of People
☐	No Appetite	☐	Fears / Phobias	☐	Home Conditions Poor
☐	Over-Eating	☐	Job Problems	☐	Unable To Have Fun
☐	Stomach Distress	☐	Depressed	☐	Worried / Anxious
☐	Bowel Disturbances	☐	Sexual Problems	☐	Guilty Feelings
☐	Always Feel Tired	☐	Take Tranquilizers	☐	Can't Make Decisions
☐	Sleep Disturbance	☐	Irritability	☐	Over-Ambitious
☐	Insomnia	☐	Dangerous Drugs	☐	Financial Problems
☐	Unable to Relax	☐	Angry Outbursts	☐	Increased Alcohol Use
☐	Recurrent Dreams	☐	Unmotivated	☐	Obsessive Thoughts
☐	Nightmares	☐	Cutting	☐	Can't Keep A Job
☐	Hallucinations / Delusions	☐	Anorexia/Bulimia Eating Disorder	☐	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
	MDP
IN THE PAST TWO WEEKS: Have you experienced any of the following? Please check all that apply:	
Pronounced weight loss or weight gain	☐ YES ☐ NO
Difficulty concentrating/indecisive Sleeping too much or too little	☐ YES ☐ NO
Recurring thoughts of death, dying	☐ YES ☐ NO
Hurting yourself Fidgety/Agitated or restless behavior	☐ YES ☐ NO
Making a plan for suicide	☐ YES ☐ NO
Taking some action toward suicide	☐ YES ☐ NO
Feeling slowed down	☐ YES ☐ NO
Feelings of worthlessness or excessive guilt	☐ YES ☐ NO
Fatigue or loss of energy	☐ YES ☐ 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?)	☐ YES ☐ NO
Has there been a period of time when you felt so irritable that you shouted at people or started fights/arguments?	☐ YES ☐ 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?	☐ YES ☐ NO
What about receiving special messages from people or from the way things were arranged around you, or from the newspaper, radio, or TV?	☐ YES ☐ 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?	☐ YES ☐ NO
Or did you do something to call attention to yourself like dressing in some odd way or doing something strange?	☐ YES ☐ NO
	SA / ETOH
Was there ever a period in your life when you drank too much?(Has alcohol ever caused you problems?)	☐ YES ☐ NO
Has anyone ever objected to your drinking - or a doctor told you to stop drinking?	☐ YES ☐ NO
Have you gone on the wagon or ever tried to cut down on your drinking?	☐ YES ☐ NO
	SA / D
Have you used any street drugs, or used prescription drugs in an amount or way that wasn't prescribed?	☐ YES ☐ 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?	☐ YES ☐ NO
If prescribed: Did you ever get hooked /dependent?	☐ YES ☐ 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)?	☐ YES ☐ 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?	☐ YES ☐ 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?	☐ YES ☐ NO
What about awful thoughts, like hurting someone against your will, or being contaminated by germs or dirt?	☐ YES ☐ 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?	☐ YES ☐ 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?	☐ YES ☐ NO
	AGR
Have you been afraid of leaving the house alone, being in crowds, standing in line, traveling on buses or trains?	☐ YES ☐ NO
Have you felt any of the following? Please check all that apply	☐ YES ☐ NO
Pounding, racing heart	☐ YES ☐ NO
Chest pain or discomfort	☐ YES ☐ NO
Fear of losing control, going crazy	☐ YES ☐ NO
Sweating	☐ YES ☐ NO
Nausea/abdominal distress	☐ YES ☐ NO
	ANX
Fear of dying	☐ YES ☐ NO
Dizzy, lightheaded or faint	☐ YES ☐ NO
Numbness or tingling sensation	☐ YES ☐ NO
Shortness of breath	☐ YES ☐ NO
Feelings of unreality	☐ YES ☐ NO
chills or hot flushes	☐ YES ☐ NO
Feelings of choking	☐ YES ☐ NO
detached from oneself	☐ YES ☐ NO
	SOC ANX
Is there anything that you were ever afraid of or uncomfortable doing in front of others like speaking, eating or writing	☐ YES ☐ NO

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