Mental Health History for Adults

The following questions are designed to be of assistance in determining your needs for treatment. Please complete this questionnaire as accurately and honestly as possible. Please print legibly. All of the information which you provide will be treated confidentially.

Date: ____________________

Name of **Insurance Subscriber**:____
Social Security # of **Insurance Subscriber**:____________________________________
Employer of **Insurance Subscriber**: ____
Insurance Plan: ____

Patient Name: ____
Patient Social Security #_______________________________ Date of Birth _____________
Home Address: ____ Phone #__________________
City/State/Zip: ____
May I write you there? Yes____ No____
May I leave a message there? Yes ____ No ____

Place of Employment: ____
Work Phone #:_______________ Occupation: ___________________________________
Level of Education: through 12th Grade____ College____

Name of your physician ____
Would you like me to contact him or her ___ If yes, phone #_____________________________

Print first and last names and age of: (for those no longer living print deceased, age at death and reason for death)
Parents ____
Brothers and Sisters ____
____
Current spouse/partner ____
Children ____
Former Spouse(s): include dates of marriage and divorce _________________________
Please list the members of your current household ______________________________
____

Have any of your relatives had any of the following:

	Yes	No	Relationship to You
Psychiatric Hospitalization	___	___	_________________
Drug Dependency (other than alcohol)	___	___	_________________
Depression	___	___	_________________
Alcoholism	___	___	_________________
Criminal Record	___	___	_________________
Psychiatric Medication	___	___	_________________
Suicide	___	___	_________________
Psychotherapy	___	___	_________________
Abuse	___	___	_________________
Anger Management Problems	___	___	_________________

Have **you** ever experienced: (Indicate P for past and C for current)

___ Depression
___ Low energy
___ Poor concentration
___ Low self esteem
___ Feelings of hopelessness
___ Feelings of worthlessness
___ Excessive guilt
___ Sleep disturbance (too much or too little)
___ Appetite disturbance (increase or decrease)
___ Thoughts of harming yourself
___ Thoughts of harming someone else
___ Social isolation
___ Communication difficulties
___ Family conflicts
___ Anger management problems
___ Anxiety/Panic
___ Job stress
___ Obsessive thoughts
___ Compulsive behaviors
___ Unresolved grief reaction
___ Divorce/Separation
___ Sexual problem
___ Eating disorder
___ Traumatic experience
___ Childhood abuse
___ Adult abuse
___ Excessive worrying
___ Excessive use of alcohol or drugs

What would you like to accomplish in therapy?

____
____
____
____

General Nature of Current Concerns: (Please place a "p" next to any concerns you consider to be your primary concerns and an "s" next to any concerns you consider to be on secondary importance.)

_____Academic problems
_____Career indecision
_____Adjusting to new environment
_____Feeling sad and depressed
_____Relationship: non-marital
_____Relationship: marital/partner
_____Relationship: family
_____Alcohol or drug related
_____Eating disorder
_____Death/Grief
_____Divorce
_____Sexuality
_____Sexual Abuse, physical abuse
_____Other: please explain________________
____

Circle any of the following words which seem to describe you fairly well: Active, Ambitious, Self-confident, Persistent, Hard-working, Nervous, Impatient, Impulsive, Quick-tempered, Excitable, Imaginative, Witty, Calm, Easily discouraged, Serious, Easy-going, Good-natured, Unemotional, Shy, Submissive, Pessimistic, Depressed, Absent-minded, Methodical, Timid, Lazy, Frequently feel hopeless, Callous, Dependable, Reliable, Cheerful, Sarcastic, Jittery, Likable, Leader, Sociable, Quite, Self-conscious, Often feel lonely.

How much of the following do you drink:

Beer	____per week	Mixed drinks	____per week
Wine	____per week	Coffee	____per week
Tea	____per week	Soda	____per week

Do you use any drugs not prescribed by your physician. ____ If yes, please list ______________________
____

How often do you exercise vigorously for 30 minutes or more ____________________________________
What do you do to relax ____
How many meals per day do you eat ____
What are your personal interests or hobbies ____

Please list any medical problems you are currently receiving treatment for:

Medical condition	Medications/Treatment

Have you received outpatient counseling services in the past? Yes___ No___ (If yes, please list)

Therapist	Reason for Counseling	Approximate Dates

Please list any medications you have taken to alleviate a mental health condition:

Medication	Dosage	Prescribing Physician	Results (Good-Fair-Poor)	Side effects?

Have you ever been hospitalized for a psychiatric reason? Yes ___ No ___ (If yes, please list)

Hospital/Treatment Center	Reason	Approximate Dates

Have you ever received treatment for substance abuse (including NA, AA)?

Yes ___ No ___ (If yes, please list)

Treatment Center/Support Group	Dates	Period of abstinence after treatment?

Please answer the following questions:

Do you smoke cigarettes? Yes ___ No ___ If yes, amount per week _______ How long? _______
Have family members or friends ever told you they were concerned about your use of alcohol or drugs? Yes ___ No ___
Has your doctor ever told you to cut down or stop using alcohol or drugs? Yes ___ No ___
Has the use of alcohol or drugs negatively affected important relationships in your life? Yes ___ No ___
Has the use of alcohol or drugs ever negatively affected your job? (i.e. late, absent, loss of job) Yes ___ No ___
Do you have allergies or any adverse reactions to medications? Yes ___ No ___ If yes, please list_______________________________________

What is your religious affiliation? ____

Did some one refer you to my practice Yes___ No___
If yes, who referred you? ____
What was the reason?
____

I understand that this information is being provided to my mental health therapist only. It is my responsibility to share relevant medical information with my Primary Care Physician.

Completed by: ____ Date: ____________________

Reviewed by: ____ Date: ___________________