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**MENTAL HEALTH QUESTIONNAIRE**

The purpose of this questionnaire is to assist you and your therapist in evaluating your problems. Please answer each question as fully and accurately as possible. This information is strictly confidential. No person outside this office is permitted to see your record without your permission except under very specific conditions.

				DATE	
<b>I. GENERAL INFORMATION</b>					
NAME			SEX	BIRTHDATE	
ADDRESS STREET CITY			ZIP CODE	AGE	RELIGION
OCCUPATION			EMPLOYER	WORK TELEPHONE #	
SPOUSE'S/PARENTS NAME			EMPLOYER		WORK TELEPHONE#
Cell P hone #			PRIMARY DOCTOR & LOCATION		SOCIAL SECURITY #
MARITAL STATUS (CHECK APPROPRIATE BOX)					
<input type="checkbox"/> SINGLE <input type="checkbox"/> ENGAGED <input type="checkbox"/> LIVING TOGETHER <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPERATED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> REMARRIED					
NAMES OF HOUSEHOLD MEMBERS		RELATIONSHIP	BIRTHDATE	AGE	EDUCATION

**II. MAIN PROBLEMS:**

1. What is the main problem you are wanting help with today? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
  
2. What was the second most important problem? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
  
3. Why did you decide to come in today instead of last week or a month from now? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

4. If you had not come for help, what do you think would have happened? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

5. When did these problems start? \_\_\_\_\_  
 \_\_\_\_\_

6. What have you done about the problem? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

7. TO MAKE CERTAIN WE DON'T MISS SOMETHING IMPROTANT, PLEASE REVIEW THE FOLLOWING LIST AND PUT A MARK IN FRONT OF ANYTHING WHICH CURRENTLY CONCERNS YOU.

STRESSFULL SITUATIONS	TROUBLESOME IMPULSES OR ACTIONS	STRONG EMOTIONS
<input type="checkbox"/> RELATIONSHIP PROBLEMS	<input type="checkbox"/> TO HURT YOURSELF	<input type="checkbox"/> DEPRESSION/CRYING
<input type="checkbox"/> FAMILY/CHILD PROBLEMS	<input type="checkbox"/> TO HURT SOMEONE ELSE	<input type="checkbox"/> ELATION
<input type="checkbox"/> WORK/SCHOOLDIFFICULTIES	<input type="checkbox"/> TO DESTROY THINGS	<input type="checkbox"/> CONFUSION
<input type="checkbox"/> FINANCIAL PROBLEMS	<input type="checkbox"/> USE ALCOHOL OR DRUGS TO EXCESS	<input type="checkbox"/> POOR MEMORY
<input type="checkbox"/> GRIEF / LOSS / DEATH	<input type="checkbox"/> COMMIT CRIMES	<input type="checkbox"/> SUSPICIOUSNESS
<input type="checkbox"/> LEGAL PROBLEMS	<input type="checkbox"/> QUIT JOB	<input type="checkbox"/> ANXIETY
<input type="checkbox"/> DISABILITY EVALUATION	<input type="checkbox"/> RUN AWAY	<input type="checkbox"/> HALLUCINATIONS
<input type="checkbox"/> MEDICAL ILLNESS	<input type="checkbox"/> EXTRA MARITAL AFAIR	<input type="checkbox"/> ANGER
<input type="checkbox"/> NO PLACE TO STAY	<input type="checkbox"/> WEIGHT / APPETITE CHANGES	<input type="checkbox"/> PANIC / FEAR
<input type="checkbox"/> DOMESTIC VIOLENCE	<input type="checkbox"/> SLEEP DIFFICULTY	<input type="checkbox"/> GUILT / WORTHLESSNESS
<input type="checkbox"/> CHANGES IN CAREERS	<input type="checkbox"/> AVOIDING SITUATIONS DUE TO FEAR	<input type="checkbox"/> NO MOTIVATION
<input type="checkbox"/> ILLNESS IN FAMILY	<input type="checkbox"/> SPEND MONEY	<input type="checkbox"/> NO ENJOYMENT
<input type="checkbox"/> PREGNANCY / NEW BIRTH	<input type="checkbox"/> ARGUE WITH OTHERS	<input type="checkbox"/> POOR CONCENTRATION
<input type="checkbox"/> MARRIAGE	<input type="checkbox"/> DRIVE RECKLESSLY	<input type="checkbox"/> MOOD SWINGS
<input type="checkbox"/> CHANGE IN RESIDENCE	<input type="checkbox"/> PROBLEM WITH SEXUAL FUNCTIONING	<input type="checkbox"/> IRRITABILITY / AGITATION
<input type="checkbox"/> DIVORCE / SEPERATION	<input type="checkbox"/> REPETITIVE BEHAVIOR PATTERNS	<input type="checkbox"/> TIRED / FATIGUE
<input type="checkbox"/> JOB LOSS	<input type="checkbox"/> PREOCCUPATION W/CERTAIN THOUGHTS	

**BEHAVIORAL / PSYCHIATRIC HISTORY**

1. Have you had similar problems in the past?  Yes  No  
 If yes, explain and describe what you did about them. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

2. Have you been in therapy before?  Yes  No  
 If yes, please explain when, with whom, and for what? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

3. Have you ever been hospitalized or gone to an emergency room with these problems? Yes No  
If yes, please explain when, which hospital and for what? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
4. Have you ever taken any psychiatric medications in the past? Yes No  
If yes, please explain when, which medication and for what kind of problem? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
5. Have you ever made a suicide attempt? Yes No  
If yes, please explain when and how: \_\_\_\_\_  
\_\_\_\_\_

## GENERAL HEALTH

1. Are you experiencing any medical problems? Yes No  
If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
2. Do you drink alcoholic beverages? Yes No  
If yes, please describe how much and how often you drink. \_\_\_\_\_  
\_\_\_\_\_
3. Has anyone ever told you that your drinking or drug use is a problem for them? Yes No  
If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_
4. Do you take drugs that are **not** prescribed by a Physician or over the counter medication? Yes No  
If yes, please describe what kind, how much and how often. \_\_\_\_\_  
\_\_\_\_\_
5. Are you currently taking any prescribed medications? Yes No  
If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_
6. Do you have any allergies? Yes No  
If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

## FAMILY PSYCHIATRIC HISTORY

Please identify any family members who have experienced or are experiencing psychiatric or substance abuse problems and mark the appropriate box below. (If no family members have experienced problems please mark the "none" box)

Father       Mother       Father's Family       Mother's Family       Brother       Sister   
Grandparent's       Aunt       Uncle       NONE

Please identify the type of psychiatric problem / treatment the family member experienced and mark the appropriate box below. Describe any details such as where, when, how long, and how severe, etc.: \_\_\_\_\_

\_\_\_\_\_

### TYPE OF PSYCHIATRIC PROBLEMS / TREATMENTS

- |  |   |
|--|---|
| <input type="checkbox"/> PSYCHIATRIC HOSPITALIZATION | <input type="checkbox"/> PARANOIA HALLUCINATIONS          |
| <input type="checkbox"/> OUT-PATIENT PSYCHIATRY      | <input type="checkbox"/> LONG-TERM PSYCHIATRIC DISABILITY |
| <input type="checkbox"/> SUICIDE ATTEMPTS            | <input type="checkbox"/> SEVERE ANXIETY / PANIC           |
| <input type="checkbox"/> DIED BY SUICIDE             | <input type="checkbox"/> ALCOHOLISM                       |
| <input type="checkbox"/> SERIOUS DEPRESSION          | <input type="checkbox"/> DRUG / TRANQUILIZER ABUSE        |
| <input type="checkbox"/> MANIC DEPRESSIVE ILLNESS    | <input type="checkbox"/> INHERITED / GENETIC DISEASES     |
| <input type="checkbox"/> SCHIZOPHRENIA               | <input type="checkbox"/> OTHER _____                      |

COMMENTS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Thank you for completing this form. Please sign and date below:

\_\_\_\_\_

SIGNATURE

\_\_\_\_\_

DATE