

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 | ___ Anger management problems |
| ___ Low energy | ___ Anxiety/Panic |
| ___ Poor concentration | ___ Job stress |
| ___ Low self esteem | ___ Obsessive thoughts |
| ___ Feelings of hopelessness | ___ Compulsive behaviors |
| ___ Feelings of worthlessness | ___ Unresolved grief reaction |
| ___ Excessive guilt | ___ Divorce/Separation |
| ___ Sleep disturbance (too much or too little) | ___ Sexual problem |
| ___ Appetite disturbance (increase or decrease) | ___ Eating disorder |
| ___ Thoughts of harming yourself | ___ Traumatic experience |
| ___ Thoughts of harming someone else | ___ Childhood abuse |
| ___ Social isolation | ___ Adult abuse |
| ___ Communication difficulties | ___ Excessive worrying |
| ___ Family conflicts | ___ 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 | ___ Alcohol or drug related |
| ___ Career indecision | ___ Eating disorder |
| ___ Adjusting to new environment | ___ Death/Grief |
| ___ Feeling sad and depressed | ___ Divorce |
| ___ Relationship: non-marital | ___ Sexuality |
| ___ Relationship: marital/partner | ___ Sexual Abuse, physical abuse |
| ___ Relationship: family | ___ 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: _____