ADULT Mental Health Questionnaire

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

I. GENERAL INFORMATION				**DATE**	
YOUR NAME	**SEX**	**BIRTHDATE**	**AGE**	**RELIGION**	
STREET ADDRESS		**HOME PHONE** ( )			
CITY	**ZIP**	**CELL PHONE** ( )			
OCCUPATION	**EMPLOYER**	**RELATIONSHIP STATUS?** i.e. Single, Married, Divorced	**WORK PHONE** ( )		
FAMILY DOCTOR		**EDUCATION**	**PAGER** ( )		
Email Address:			**Referred by:**		

Household Member Names	Relationship	Birthdate	Age	Education	Occupation

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II. MAIN PROBLEM - This section is designed to help you and your therapist focus on some of the changes you would like to make.

1. What is the main problem you would like help with today?

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2. What was the second most important problem?

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3. Why did you decide to come in today instead of last week or a month from now?

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

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5. When did these problems start?

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6. What have you done about the problem?

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7. To make certain I do not miss something important, please review the following list and put a mark in front of anything which currently concerns you.

Stressful Situations		Troublesome Impulses		Strong Emotions	
	Relationship Problems		To Hurt Yourself		Depression / Crying
	Family / Child Problems		To Hurt Someone Else		Elation
	Work / School Problems		To Destroy things		Confusion
	Financial Problems		Over use Alcohol / Drugs		Poor Memory
	Grief / Loss / Death		Commit Crimes		Suspiciousness
	Legal Problems		Quit Job		Anxiety
	Disability Evaluation		Run Away		Seeing / Hearing Things
	Medical Illness		Extra Relational Affair		Anger
	No Place to Stay		Weight / Appetite Change		Panic / Fear
	Domestic Violence		Sleep Problems		Guilt / Worthlessness
	Change In Career / Work		Avoiding Situations		Lower Motivation
	Illness In Family		Over Spending / Debt		Nothing Is Fun
	Pregnancy / New Birth		Argue With Others		Poor Concentration
	Marriage		Drive Recklessly		Mood Swings
	Change In Residence		Sexual Functioning		Irritability / Grumpy
	Divorce / Separation		Repeating Behaviors		Tired / Fatigue
	Job Loss		Preoccupation w/thoughts		

III. BEHAVIOR / MENTAL HEALTH HISTORY - This section is for you to let your therapist know how long your current symptoms have been going on and what steps you have taken to address these difficulties.

8. Have you had any similar problems in the past? – **Please circle YES NO**

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9. Have you been in therapy before? **Please circle YES NO**

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10. 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 you were treated for (example, shortness of breath).

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11. Have you ever taken **any** psychiatric medication in the past? **YES NO**
If Yes, please explain when, which medication and for what kind of problem? (such as depression, anxiety, attention / concentration, etc.)?

12. Have you **ever** made a suicide attempt? **Please circle YES NO**
If Yes, please explain when and how.

13. What have you done about the problem?

IV. GENERAL HEALTH - This section is for you to let your therapist know about any physical health issues that could impact your therapy experience.

14. Are you experiencing **any** medical problems? **Please circle YES NO**
If Yes, please describe.

15. Do you drink alcoholic beverages? **Please circle YES NO**
I see myself as a: 1) non 2) light 3) occasional 4) heavy - drinker

16. Has anyone **ever** told you that your drinking or drug use is a problem for them?
If Yes, please explain who and when. **Please circle YES NO**

17. Do you have any concerns about your sexuality? **Please circle YES NO**

Example: self or partner's lack of desire; problems with climax; orientation; pornography or other behaviors? If Yes, please describe.

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18. In the last 90-days, have you taken **any** supplements, vitamins, or herbal remedies, example: St. John's Wort?
    If Yes, please describe what kind and amount. **Please circle YES NO**

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19. In the last 90-days, have you taken **any** drugs that are not prescribed for you?
    If Yes, please describe what kind and amount. **Please circle YES NO**

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20. In the last 90-days, have you taken **any** over the counter medication?
    If Yes, please describe what kind and amount. **Please circle YES NO**

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21. In the last 90-days, have you taken **any** prescription medication?
    If Yes, describe what kind, how much / often? **Please circle YES NO**

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22. Do you have **any** allergies?
    If Yes, describe what you are allergic to. **Please circle YES NO**

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IV. FAMILY PSYCHIATRIC / SUBSTANCE USE or ABUSE HISTORY - This section is for you to let your therapist know about any MENTAL HEALTH or ADDICTIVE BEHAVIOR PROBLEMS in your family.

	Depression	Anxiety	Alcohol Abuse	Drug Abuse	Food Abuse	Other, Please List
Father						
Mother						
Step Father						
Step Mother						
Father's Family						
Mother's Family						
Brother(s)						
Sister(s)						
Grand Parents						
Aunt						
Uncle						
Other						

Additional comments on above:

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Mental Health, Alcohol, Drug or Food Issues with your spouse, partner, child(ren).

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V. MENTAL HEALTH TREATMENT HISTORY If you or a family member has been previously diagnosed with or treated for one of the following, please indicate.

	SELF **Circle**	**Family Member(s). If Yes, please write relationship, i.e. Mom, Dad, Mom's Aunt**
In-Patient Psychiatric Hospitalization?	**YES / NO**	
Out-Patient Therapy	**YES / NO**	
Suicide Attempt(s)	**YES / NO**	
Died By Suicide	N / A	
Serious Depression	**YES / NO**	
Manic Depression / Bipolar	**YES / NO**	
Schizophrenia	**YES / NO**	
Paranoia, Hallucinations	**YES / NO**	
Long-Term Psychiatric Disability	**YES / NO**	
Severe Anxiety / Panic	**YES / NO**	
Alcoholism	**YES / NO**	
Recreational / Street Drug Abuse	**YES / NO**	
Prescription Drug Abuse	**YES / NO**	
Other	**YES / NO**	

Comments – What other information do you consider important for your therapist to know about?

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

____________________________________ ____________________

SIGNATURE **DATE**

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