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MENTAL HEALTH HISTORY AND SYMPTOMS

Basic Background Information:

FIRST NAME _____ LAST NAME _____ DATE OF BIRTH _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

How many times have you been married? _____ How long has your current marriage been? _____

Religious Affiliation: _____

Employment Status: ☐ Full time ☐ Part time ☐ Not employed ☐ Retired

Company Name: _____ Job Title: _____

Education: Highest grade level completed: _____ Degree: _____ Other: _____

Biological Parent Information: (for clients under age 18 years of age)

Relationship Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Never married ☐ Widowed

Living Environment: ☐ Same Home ☐ Different Homes

Legal custody arrangement: _____

Physical custody arrangement: _____

Self-Care: (please check all that apply)

- ☐ Balanced diet
- ☐ Exercise
- ☐ Adequate sleep
- ☐ Listen to music
- ☐ Engage in hobbies
- ☐ Block out time for self
- ☐ Socialize
- ☐ Vent to supports
- ☐ Positive self-talk
- ☐ Journal / Write
- ☐ Read
- ☐ Pray

Current Symptoms: (please check all that apply)

- ☐ Anxiety
- ☐ Feeling tense
- ☐ Irritability
- ☐ Fatigue
- ☐ Indecisiveness
- ☐ Obsessive thoughts
- ☐ Shy around others
- ☐ Poor boundaries
- ☐ Porn addiction
- ☐ Self-harm behaviors
- ☐ Feelings of inferiority
- ☐ Difficulty staying organized
- ☐ Unable to relax
- ☐ Heart palpitations
- ☐ Difficulty sleeping
- ☐ Unmotivated
- ☐ Bowel disturbances
- ☐ Self-critical
- ☐ Lonely
- ☐ Withdrawing from others
- ☐ Restricting food
- ☐ Aggressive behaviors
- ☐ Memory problems
- ☐ Uneasy in social settings
- ☐ Excessive sweating
- ☐ Low mood
- ☐ Loss of interest in activities
- ☐ Mood swings
- ☐ Poor work performance
- ☐ Drink too much
- ☐ Abuse recreational drugs
- ☐ Low self-worth
- ☐ Weight gain / loss
- ☐ Easily distracted
- ☐ Excessive use of electronics
- ☐ Persistent worrying
- ☐ Racing thoughts
- ☐ Crying episodes
- ☐ Over or under eating
- ☐ Wanting to run away
- ☐ Suicidal thoughts
- ☐ Smoke too much
- ☐ Lie often
- ☐ Impulsive
- ☐ Overeating
- ☐ Blaming others

Current Symptoms; *continuing* (please check all that apply)

- ☐ Defies authority figures
- ☐ Steals
- ☐ Strained relationship with parents
- ☐ Attention seeking
- ☐ Deliberately annoying
- ☐ Difficulty maintaining attention
- ☐ Interrupts others
- ☐ Argumentative

Current Stressors: (please check all that apply)

- ☐ Grief
- ☐ Divorce
- ☐ Marriage difficulties
- ☐ Life transition
- ☐ Work stress
- ☐ Health problems
- ☐ Pregnancy
- ☐ Employment issues
- ☐ Parenting stress
- ☐ Substance use
- ☐ Fertility issues
- ☐ Financial problems
- ☐ Custodial issues
- ☐ Eating disorder
- ☐ Abortion
- ☐ Legal problems
- ☐ Family conflict
- ☐ Gender identity
- ☐ Trauma
- ☐ Gambling
- ☐ Care of elders / loved ones
- ☐ Victim of abuse
- ☐ Co-dependency

Medical / Psychiatric History: (please check all that apply)

- ☐ Depression
- ☐ Bipolar disorder
- ☐ Muscular disorder
- ☐ Cancer
- ☐ Asthma
- ☐ Anxiety disorder
- ☐ Nerve disorder
- ☐ Cirrhosis
- ☐ Migraines
- ☐ Personality disorder
- ☐ Auto-immune disorder
- ☐ Colitis / IBS
- ☐ Traumatic brain injury
- ☐ Learning disorder
- ☐ Psychotic disorder
- ☐ Thyroid disease
- ☐ Attention deficit disorder
- ☐ Any sexually transmitted illness

Risk Assessment:

Are you having any current suicidal thoughts? ☐ Yes ☐ No

Have you ever attempted suicide? ☐ Yes ☐ No

Has anyone close to you completed suicide? ☐ Yes ☐ No

Do you currently use nicotine products? ☐ Yes ☐ No

Do you currently use recreational drugs? ☐ Yes; how often?_____ ☐ No

Do you drink alcohol? ☐ Yes; how much / how often?_____ ☐ No

Do you drink caffeine? ☐ coffee, ☐ tea, ☐ pop; _____ ounces per day ☐ No