Mental Health History

The following information is needed to best help you. If you are unable to complete some parts, leave them blank and we will complete them together in session.

SECTION I: IDENTIFYING INFORMATION

Today's Date _____

Name_____ Date of Birth_____ Age_____

Address_____ City/State_____Zip_____

Phone_____ If I need to call you, may I leave a message? Yes___ No___

E-mail (optional)_____

SECTION III: MEDICAL HISTORY

Name of Physician_____ Date of your last physical exam: _____

Please list any significant current or past significant medical issues:

List all current or past treatment by a psychiatrist, psychologist, therapist, or counselor.

Problem/Diagnosis	Where	Therapist	When?	Helpful? (Y/N)

If applicable, please list all medications you are now taking or have taken in the past three months, **including birth control pills, vitamins, herbs and supplements**.

SECTION II: DESCRIPTION OF PRESENTING PROBLEM

How can counseling be most helpful to you? Please tell me what you want to work on or change while in counseling (e.g. Goals for Counseling) and how long this has been an issue for you.

How would you estimate the severity of the problem at this time? (Place an "X" on the line below).
Mild *Moderate* *Serious* *Severe*

Have you ever experienced: (Please mark all that apply)

__Emotional abuse __Physical abuse __Eating disorder __Suicide attempts
__Sexual abuse __Sexual assault __Drug/alcohol abuse

Comments:

What symptoms contributed to you coming in today? (Please check all that apply)

__overeating	__restless	__rapid heart rate	__compulsive behaviors
__taking drugs	__depressed mood	__sweating	__impulsive behaviors
__odd behavior/thoughts	__crying	__trembling or shaking	__fears/phobias
__recent weight gain	__difficulty concentrating	__shortness of breath	__anxiety
__recent weight loss	__low motivation	__muscle tension	__work problems
__recent appetite changes	__aggressive behavior	__anger outbursts	__distrust
__social withdrawal	__feeling worthless	__nightmares	__jumpy
__family emotional problems	__digestive problems	__easily distracted	__dizzy or lightheaded
__chest pain	__sleeping too much	__decreased sleep	__fatigue/loss of energy
__difficulty falling asleep	__problems with school	__housing problems	__obsessions
__difficulty staying asleep	__pain	__drinking alcohol	__relationship problems
__ traumatic event	__financial problems	__can't turn mind off	__grief

__ other: _____

SECTION IV: RELATIONSHIPS

Who do you live with currently?

Name	Age	Relationship to you	Supportive? Y / N

Are your parents divorced? Yes _____ No _____ If so, how old were you when they divorced? _____

Are you: Single ___ Dating ___ Married / Partnered ___ Divorced ___ Widowed ___

If applicable, describe your relationship with your current partner (place an X on the line below).

Major Problems Minor problems Satisfactory Fulfilling

If applicable, how long have you been in this relationship? _____

SECTION V: OTHER

What role does spirituality play in your life?

Do you regularly engage in hobbies or activities? Yes___ no___

List your regular hobbies and activities below:

Hobby/activity	Frequency (e.g. daily, weekly, monthly)

Describe your involvement with the criminal justice system (past and current):

What else do I need to know to assist you?