

Mental Health Questionnaire

What brings you in today?

List any previous counseling, psychiatric treatment, hospitalizations or residential treatment

(use back if necessary):

Counselor/Hospital: _____ Location: _____ Dates: _____

Reason : _____

Therapist/Hospital: _____ Location: _____ Dates: _____

Reason: _____

Therapist/Hospital: _____ Location: _____ Dates: _____

Reason: _____

List any previous diagnoses: _____

What did you like/dislike about treatment? _____

Are you currently experiencing any thoughts of suicide? Yes No If yes, please explain:

Have you had thoughts of suicide in the past? Yes No If yes, please explain:

Are you currently having thoughts of hurting someone else? Yes No If yes, please explain:

Have you had thoughts in the past of hurting anyone else? Yes No If yes, please explain:

What are your goals for treatment?

What has been helpful in the past?

SUBSTANCE ABUSE AND COMPULSIVE BEHAVIORS

Are you currently or have you ever struggled with substance abuse? (alcohol, tobacco, marijuana, caffeine, cocaine, crack, heroin, amphetamines, ecstasy, K2, hallucinogens, benzodiazepines, pain medications or other) Yes No

Please list:

| Substance | Age at first use | Amount of current use | Frequency of current use | How it was used |
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Have you ever been in residential treatment for substance abuse? Yes No

If yes, when and how long? _____

Did you complete treatment? Yes No

If yes, what was the outcome? (length of sobriety, etc.) _____

If no, what was the reason for discharge? _____

Do you have a family history of substance abuse? Yes No

If yes, please explain: _____

Have you ever felt that you ought to cut down on your drinking or drug use? Yes No

Have people expressed concern about your drinking or drug use? Yes No

Have you ever felt bad or guilty about your drinking or drug use? Yes No

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or get rid of a hangover? Yes No

Are you currently or have you ever struggle with gambling? Yes No

If yes, please describe: _____

Are you currently or have you ever struggled with food? Yes No

If yes, please check all that apply: Overeating Restricting Bingeing Purging (vomiting, using laxatives, etc.) Compulsive Exercise

How often do you engage in these behaviors? _____

Are you currently or have you ever struggled with excessive sexual behaviors? Yes No

If yes, please check all that apply: Pornography Masturbation Sexual intercourse

Other: _____

How often do you engage in these behaviors? _____

SYMPTOMS

Please rate each symptom that you experience using a scale from 0 to 3.

0 = None, 1 = Mild, 2 = Moderate, 3 = Severe

Feeling anxious/uptight ___ Excessive worrying ___ Not being able to relax/Restlessness ___

Muscle Tension ___ Irritability ___ Feeling panic ___ Racing Thoughts ___ Excessive guilt ___

Unable to calm yourself down ___ Having obsessive/ruminating thoughts ___ Feeling out of control ___

Dwelling on certain thoughts or images ___ Fearing something terrible is about to happen ___

Avoiding certain thoughts or feelings ___ Difficulty leaving the house ___ Nightmares ___

Flashbacks ___ Hypervigilant ___ Troubling or painful memories ___ Missing periods of time ___

Trouble remembering things ___ Feeling numb ___ Feeling detached from all or part of your body ___

Feeling unmotivated ___ Feeling unreal, strange or foggy ___ Loss of interest in many things ___

Hopelessness ___ Difficulty concentrating ___ Difficulty making decisions ___ Isolation ___

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Feeling worthless or like a failure ___ Feeling sad more days than not ___ Sleeping too much ___
Fatigue ___ Crying frequently ___ Difficulty falling asleep and/or staying asleep ___
Recent Change in weight ___ Thinking too much about death ___ Withdrawing inside yourself ___
Thoughts of killing yourself ___ Feeling out of control ___ Thought of hurting or killing others ___
Bingeing on food ___ Restricting food/fluid intake ___ Use of purging behaviors ___ Feeling empty ___
Fear of being fat ___ Dissatisfied with physical appearance ___ Frequent mood swings ___
Feeling self-critical or blaming yourself ___ Self-harming behaviors (cutting, burning, etc.) ___
Feeling resentful or angry ___ Fears of being alone or abandoned (real or imagined) ___
Feeling irritable/frustrated ___ Feeling rage ___ Spending sprees ___ Decreased need for sleep ___
Increased self-esteem ___ Feelings or thoughts of grandiosity ___ Trouble finishing things ___
Financial problems ___ Aggressive towards others ___ Increased sex drive ___ Decreased sex drive ___
Reckless behaviors (driving too fast, drinking excessively) ___ Black outs after drinking ___
Stealing ___ Marital problems ___ Family problems ___ Legal problems ___ Frequent lying ___
Needing frequent redirection to a task ___ Excessive movements ___ Difficulty sitting still ___
Unable to remember a sequence of tasks ___ Excessive talking ___ Frequent interruption ___
Fire setting ___ Hurting animals ___ Physically hurting other people ___

RELATIONAL INFORMATION

Current relationship status:

Single Dating Engaged Married Domestic partner Separated Divorced Widowed

Number of previous marriages _____ Are you content with your current relationship? Yes No

If no, briefly explain: _____

If separated or divorced, how long? _____ If widowed, how long? _____

Partner's name: _____ How many previous marriages? _____

How long have you known your partner? _____ Partner's age: _____

Partner's Occupation: _____

What words would you use to describe your partner? _____

With whom do you currently live? (Check all that apply)

Alone Partner/Spouse Children Parent(s) Siblings Roommate Other: _____

CHILDREN

List your children (living or deceased)

| Name | Sex/Gender | Current age or year of death | Living with you? | Describe Relationship in one word |
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Have you ever placed a child for adoption? Yes No If yes, when? _____

Have you ever had a miscarriage? Yes No If yes, when? _____

Have you ever had an abortion? Yes No If yes when? _____

Any involvement with Department of Children and Families? Past Present

If yes, please explain: _____

FAMILY OF ORIGIN

List parents, guardians, siblings, step family, and other family members who impacted you

| Name | Current age or year of death | Relationship to you | Describe relationship in one word |
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Do you have any family history of mental illness? Yes No If yes, please explain:

| Relative | Diagnosis | Age at diagnosis |
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Any history of neglect and/or verbal, physical, emotional or sexual abuse? Yes No

If yes and comfortable discussing: _____

Do these events still impact your life today? Yes No

EMPLOYMENT INFORMATION

Employer: _____ Length of Employment: _____

Occupation: _____ Average hours worked per week: _____

Are you satisfied with your current employment? Yes No

If no, please describe: _____

EDUCATIONAL INFORMATION

Highest education completed: _____ (year of high school, GED, # of years of college, etc.)

Are you currently in school? Yes No If yes, what school? _____

If you are currently enrolled in school, please answer the following:

Describe your attendance: _____

Describe your relationship with teachers: _____

Describe your relationship with peers: _____

Describe your academics: _____

Are you satisfied with your academic achievement? Yes No

If no, please describe: _____

MEDICAL HISTORY

Primary care physician: _____ Last date seen: _____

Reason for visit: _____

Are you currently receiving medical treatment? Yes No

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If yes, please explain: _____

Do you see a psychiatrist? Yes No If yes, who? _____

Are you currently taking any medications? Yes No

If yes, please list:

Do you take medications as prescribed? Yes No

If no, please explain: _____

Please list any conditions, illnesses, surgeries or other related treatments (use the back if necessary):

LEGAL HISTORY

Are do you currently have any pending criminal charges? Yes No

If yes, please explain: _____

Are you currently on probation? Yes No

If yes, please explain: _____

Have you ever been arrested/convicted of a crime? Yes No

If yes, please explain: _____

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RELIGIOUS BACKGROUND

Do you identify with any particular religious and/or spiritual group? Yes No

If yes, please identify: _____

Do you feel that your religious and/or spiritual beliefs will impact your treatment? Yes No

If yes, please explain: _____

Are there any other cultural or ethnic considerations that I should be aware of? Yes No

If yes, please explain: _____

Terms of Service I hereby give Alan Zupka, Registered Mental Health Counselor Intern, MA, NCC
permission to provide counseling services to the abovementioned client(s):

Client signature: _____ Date: _____

Counselor signature: _____ Date: _____