Alan Zupka, Registered Mental Health Counselor Intern, MA, NCC

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:

_____

_____

Your Goals

Please share a little about what kind of help you think I can provide as we work together in therapy.

Check the appropriate reply:

□ My goals are CHANGE ORIENTED. This means I want to learn some skills to manage my circumstances and my mental wellness in a healthier way. I am motivated to make changes to my thoughts, feelings, and /or behaviors by working on new skills inside and outside of therapy sessions.

□ My goals are SUPPORT ORIENTED. This means I want someone to listen to and validate my experiences. I need help making sense of what happens/happened in my head, in my heart, or in my life. It would help me most to just have someone I trust to talk to.

□ My goals are BOTH change and support oriented.

□ I am unsure about my goals for therapy. I need to talk more about this when we meet.

What are your specific 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

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 ___

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**

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

Do you have any family history of mental illness? Yes □ No □ If yes, please explain:

Relative	Diagnosis	Age at diagnosis

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: _____

Described 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 □

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: _____

_____

_____

_____

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 above mentioned client:

Client signature: _____ Date: _____

Counselor signature: _____ Date: _____