Mental Health Self-Report

Name: ______________________________________ Date: _______________

Home phone: (_____)_________________________ Cellular:(______)________________________

Work/Other: (_____)__________________________ Pager:(______)__________________________

Which number(s) can I use to leave messages? □None □Home □Cellular □Work/Other

Home Address: Mailing Address: (If different)

____ ____

____ ____

____ ____

Email: _________________________________

INSURANCE (check all that apply) : ____
□Medicare #_________________ □Private/Self-Pay:____

Age: ______ Date of Birth: ____________

Citizenship/Nationality: □USA □Other ________________ Gender: □M □F □Transgender (M→F)(F→M)

Race/Ethnicity: □African American/Black □Asian/Pacific Islander □Hispanic/Latino □Native American
□White □Other____

Languages: □English □Spanish □Other ____
Any hearing problems? □No □Yes ____
Any reading/writing problems? □No □Yes ____

Residence: □House/Apt. □Supportive □Homeless □Transitional (SRO/Hotel) □Other_______________

Who else lives at home? Names/Relationships____

Emergency Contact:
Name/Relationship__________________________________ Phone: (_____)___________________
Address: ____

Children: Dependants *living at home*? □No □Yes (List names, ages, custody, living arrangements): ____
____
____
Other Children: (List names, ages, custody, & living arrangements): __________________________
____

What is your main complaint/problem and would you like from your treatment here? ___________________
____
____

Where were you born?____

Where were you raised?____

Who was in your home growing up? □Mother (name______________, age_____ alive? □No □Yes occupation_____________) □Father (name______________, age_____ alive? □No □Yes occupation_____________) □Step-parent(s) (name(s)_________________________, age(s)________ alive? □No □Yes occupation___________________) □Brother(s)/Sister(s) (name(s) age(s): __________
____
□Grandparent(s) □Aunt(s)/Uncle(s) □Cousin(s) □Other ______________________________________

What was your home life like?

□Calm □Chaotic □Supportive □Stressful □Happy □Yelling □Violent □Drugs/Alcohol □Strict □Religious □Single parent □Parents had relationship problems □Financial problems □Other
____

Did you have any problems growing up? □No □Yes

□Teased □Verbally Abused □Physically Abused □Sexually Abused □Isolative □Spoiled □Unhappy □Bedwetting □Separation anxiety □Attention or hyperactivity problems □Other
____

Were you ever in foster care, group home(s) or other "institution(s)"? □No □Yes *(When? What?)* _____
____

Learning, reading, attention or school problems? □No □Yes □Special Education

Education: (Note highest grade/degree achieved. If dropped out, why?)

□ _____Grade □HS grad □GED □Vocational □Some College □Associates □Bachelors □Masters □Doctoral ____

Work History (Check all that apply): □Employed (□Full-time □Part-time □Off the books) □Unemployed

What do/did you do? ____

Have you ever been arrested? □No □Yes Have you ever been incarcerated? □No □Yes

Military Service: □No □Yes (Circle) Army/Navy/Marines/Coast Guard □Combat □Honorable discharge

Current Relationships (Check all that apply): □None □Single □Dating □Anonymous partners
□Married (____times) (when_____________) Engaged (____times) □"Widowed" (when ______)
□Divorced (when______) □Common-law/Domestic Partner □Significant Other

Current partner's/spouse's name:_________________________ How long together?__________

Is he/she HIV(+)? □No □Yes □Unknown

Who can you count on to help provide emotional support? □No one
□Mother □Father □Sister(s)/brother(s) ______________________________ □Child(ren)
___________________________ □Significant Other _______________ □Friend(s)) _________________
□Other ____

Do you use spirituality/religion as a support? □No □Yes ____________________________________
____

Psychiatric History

Are you ***currently*** in counseling/therapy (Include groups) No Yes
Who is your therapist/psychiatrist? ______
Where (phone/address)? ______
When started & why? ______

Are you prescribed medication(s) for any emotional, (depression, anxiety, etc.) or sleep problems? No Yes Medication(s): ______
Who prescribes these? Psychiatrist Other doctor ______

Have you ***ever*** received counseling/therapy No Yes;
What kind of treatment? When, where, with whom? And why did you stop? *(*List all prior treatment experiences, use back of this page, or page 6 if needed.)* ______

______

Have you ***ever*** been prescribed medication(s) for depression, anxiety, sleep or other emotional problems? No Yes; *(*List all medications, use back of this page, or page 6 if needed. Include name of medication, when prescribed, why, dosages, positive and negative effects*)
______

______

Have you ***ever*** been **hospitalized** for emotional problems or drug use? No Yes (when______)

Do you believe any one in your family has a history of mental illness? No Yes Maybe
Who and what was/is wrong? ______

Has any family member or close friend committed suicide? No Yes

Have you *ever* thought about or attempted to kill or hurt yourself (include cutting/burning)? No Yes
Recently ? No Yes

Have you ever been assaulted, shoved, slapped? No Yes By whom? Partner Parent Child Friend Stranger Other ______

Have you ever been raped or sexually assaulted? No Yes By whom? Partner Parent Child Friend Stranger Other ______

Do you have any current threats of sexual/physical assault or domestic violence against you? No Yes

Have you ever thought about or attempted to harm or kill someone else? (Include shoving, slapping assault/domestic violence, rape) No Yes Have you ever had sexual or violent thoughts/actions about children? No Yes ______

______

Do you have thoughts about harming someone now? No Yes ______

Have you ever experienced or witnessed any significant traumatic event involving actual or threatened death or serious injury to you or others? (Severe accident, War, Fire, Torture…) No Yes ______

______

How do you handle disagreements with people or particularly upsetting or frustrating situations?
Talk calmly Avoid or walk away Agree even if you don't agree Threaten Get angry and argue Shoving/slapping Physical fighting Other ______

Sexual History - Behavioral Compulsions

Do you have any concerns about, or discomfort with your: ☐No ☐Yes
☐Sexual identity (Gay, Straight, "Bi",...) ☐Gender identity (How you feel as a man/woman) ☐Unsafe sexual behaviors ☐Compulsive sexual behaviors ☐Other ______________________________

If your are HIV+ Do you have any concerns with telling your (potential) sexual partner(s) about (or their discovering) your HIV status? ☐No ☐Yes Would you like help managing disclosure issues? ☐No ☐Yes

During sex or masturbation do you ever have *difficulties with* any of the following? (Check all that apply):
☐No problems, good/satisfactory sex life.
(Males) ☐Erections ☐Premature ejaculation ☐Ejaculation ☐↑Interest ☐↓Interest ☐Anxiety/tension ☐With partner ☐Masturbation ☐Other ______________________
(Females) ☐Becoming excited ☐Premature orgasm ☐No Orgasm ☐↑Interest ☐↓Interest ☐Anxiety/tension ☐With partner ☐Masturbation ☐Other ______________________

Protection use/Birth control method: (Check all that apply)
Condoms/Dams or other barrier devices: ☐Always ☐Usually ☐Sometimes ☐Never
☐Pill ☐Tubal ligation/vasectomy ☐Creams ☐Rhythm/withdrawal ☐Other ________________

(F) Pregnant now? ☐Yes ____mo. ☐No Desire/plan to become pregnant? ☐No ☐Yes
____#Pregnancies ☐Aborted/miscarried_____ ☐Children adopted/foster Care ☐Never pregnant

Chemical Dependence History – Behavioral Compulsions

Do you have a history of, or current problems with, drug or alcohol use? ☐Yes ☐No ☐In recovery
Injection drug use? ☐No ☐Yes, *Past* ☐Yes, *Presently*

Past drug or alcohol use/abuse: How old were you when you started drinking/using drugs? _________
☐Alcohol ☐Marijuana ☐Cocaine/Crack ☐Heroin/Opiates ☐PCP ☐Stimulants/"Speed"
☐Barbiturates/Benzodiazepines/Sedatives ☐LSD/Hallucinogens ☐"Club Drugs"/ Ecstasy, etc.
☐Other__________

Current drinking &/or drug use: ☐Yes ☐No ☐In recovery
☐Alcohol ☐Marijuana ☐Cocaine/Crack ☐Heroin/Opiates ☐PCP ☐Stimulants/"Speed"
☐Barbiturates/Benzodiazepines/Sedatives ☐LSD/Hallucinogens ☐"Club Drugs"/ Ecstasy, etc.
☐Other__________

How often do you use? ☐Daily ☐Several days/week ☐ Week Ends ☐☐<2x/Month ☐Rare/social
When, what and how much ($) did you last use? ____________________________________

Do you feel that you have a problem with substance use? ☐No ☐Yes
Would you like help with reducing, controlling or stopping your substance use? ☐No ☐Yes
Have you ever had help or treatment for you substance use? ☐No ☐Yes
☐Detox ☐Rehab ☐Therapeutic Community ☐12-Step Group (AA/NA/CA) ☐Other ___________
Are you taking Methadone or another medication to help with your drug use? ☐No ☐Yes

Caffeine: Cups/glasses per day: Coffee _____ Tea _____ Soda _____
Cigarettes/Tobacco: ☐Never ☐Quit ______months/yrs ago ☐Yes, _____Packs/Cigarettes per day
Age started? _____ Desire to quit or reduce use? ☐No ☐Yes

Do you have trouble with any other behaviors or thoughts that you feel unable to control, and/or that are interfering with your life? ☐No ☐Yes ☐Managing money ☐Shopping ☐Gambling ☐Internet ☐Washing ☐Hair pulling ☐Eating habits ☐Counting things ☐Saving/Hoarding things ☐Other

Other MEDICAL History/Info

Primary Medical Provider: ____________________________ Clinic/Hospital: _______________________
Telephone: __________________ Address: ____
Other Medical Provider: ____________________________ Clinic/Hospital: _______________________
Telephone: __________________ Address: ____

Allergies: *Medications* ____
Allergies: *Food/Other* ____

Have you ever been HIV tested? ☐No ☐Yes Date last known (-) test:_______________
If HIV+ Date Known HIV(+)________ CD4: _________ Viral Load: _________ ☐*Undetectable*

Do you have any history of or do you suffer from? (Check all that apply. Circle if choice.)

No	Now	Ever		No	Now	Ever	
			Asthma/Difficulties Breathing				Thyroid/Endocrine/Hormonal
			(High / Low) Blood Pressure				Head Trauma
			Heart problems				Loss Of Consciousness
			Liver problems/ Hepatitis				Meningitis/CNS infections
			Kidney problems/ Dialysis				Stroke
			GYN/Urologic				Seizures/Epilepsy
			Diabetes/Blood sugar problems				Cancer
Other, or descriptions of above:							

No	Now	Past 3 mo.		No	Now	Past 3 mo	
			Diarrhea/Constipation				Weakness
			Nausea/ Vomiting				Fatigue/ Loss of energy
			Loss of appetite/ Change in taste				Muscular problems
			Weight gain or Weight loss				Back or Joint problems
			Body Image concerns				Tremor/ Movement problem
			Poor eating habits				Rash, skin or hair problems
			Dizziness, Light-headedness				Eye/ Vision Problems
			Headache				Ear/ Hearing Problems
			Pain				Teeth/Dental
			Insomnia/Apnea				
Other, or descriptions of above:							

Is your primary medical provider aware of these problems? □No □Yes

What medications are you currently prescribed? □None ____
____

How often do you forget or chose not to take your medicines?
□More than once a day □Once a day □About once a week □Less than once a week □Once or twice a month □Never, I always take every dose.

Have you ever had a significant illness, injury or surgery (as a child or adult)? □No □Yes
____

Preferred pharmacy: Name: ____
Telephone: ____________________ Address: ____
Fax: __________________________ Pharmacist/contact (if known) ____________________________

What "over the counter" medications, vitamins and herbs do you frequently use? ____________________
____

Do you use complementary therapies/treatments? □No □Yes (Check/Circle all that apply.)
□Nutrition □Acupuncture □Herbal, (Chinese/ Western) □Homeopathy □Chiropractic □Massage
□Therapeutic Touch □Guided relaxation □Meditation □Exercise/Yoga □Other ______________________

Anything else that you feel I should know about you? Or any specific questions which you have for me?