Mental Health History

The following information is needed to best help you. Please clearly print your response to each question. This will help save time in your first session. If you are unable to complete some parts, then leave them blank and you will have a chance to complete them with your counselor. Case records are strictly confidential.

SECTION I: IDENTIFYING INFORMATION

Today's Date: ______________

Name____ Student A#_________________________ Date of Birth______________

Address____ City________________ Zip____________ Home Phone_________________

Other Phone__________________ E-mail (optional)_____________________ Year(s) at TESC_____ Year in School______ Age______

Who do you live with currently?

Name	Age	Relationship to you	Supportive? Y / N

SECTION II: DESCRIPTION OF PRESENTING PROBLEM

How can the Counseling Center be most helpful to you? Please tell us what you want to work on or change in counseling: (e.g. Goals for Counseling)

____

____

____

____

How long has this been a significant problem for you? *Please be specific (i.e., not "all my life").*

____

____

How would you estimate the severity of the problem at this time? (Place an "X" on the line below)

Mild — Moderate — Serious — Severe

Are you currently considering leaving the college? ___________

To what degree have the problems you've come into the Counseling Center for contributed to your thoughts about leaving? (Place an "X" on the line below)

Not at all — Mildly — Moderately — Severely

Have you ever been given a mental health diagnosis in the past from a mental health professional? Yes____ No____
If yes, as you understand it, what is/was that diagnosis?____

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	__vomiting
__recent appetite changes	__aggressive behavior	__outbursts of temper	__distrust
__social withdrawal	__feelings of worthlessness	__nightmares	__jumpy
__family emotional problems	__stomach problems	__easily distracted	__dizzy or lightheaded
__chest pain	__sleeping too much	__decreased need for sleep	__fatigue/loss of energy
__difficulty falling asleep	__problems with school	__housing problems	__obsessions
__difficulty staying asleep	__pain	__drinking alcohol	__relationship problems
__experienced a traumatic event	__financial problems	__can't turn my mind off	__other: ___________________

If applicable, please describe any incidents or problems that may have contributed to this problem (e.g., problem with academic program, relationship ending, past trauma, etc.):

____

____

In the past, what has been helpful to you in dealing with this problem? ____

____

____

____

SECTION III: MEDICAL HISTORY

Name and location of Physician____ Date of your last physical exam: ____________

SECTION III: MEDICAL HISTORY (continued)

Please list any significant past or current **health, medical, or psychiatric issues** (including anything resulting in hospitalizations).

Dates | Problem & Treatment | Were you hospitalized (Y/N) | How Long?

____

____

____

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

Emotional abuse_________ Physical abuse_______ Sexual abuse_________ Sexual assault__________

Have you, or anyone else, ever been concerned that you may have an eating disorder? Yes____ No____

Have you **ever had treatment by**, or are you **currently seeing**, a psychiatrist, psychologist, therapist, or counselor? Yes ___ No ___

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

____

____

SECTION IV: MEDICATIONS AND SUBSTANCES USED

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**.

Medication | Dosage | Person prescribing | How long have you been taking this? | Helpful (Y/N)

____

____

____

____

If applicable, amount of **caffeinated** beverages per day: coffee ________ soda ________ espresso ________ tea ________

If applicable, number of cigarettes smoked per day:________ If applicable, how often do you use marijuana per week?________

Consider a typical week during the **past month**. Please fill in a number for each day of the week indicating the typical number of drinks you usually consume on that day and the typical number of hours you usually drink on that day.

1 Drink = 12 oz. beer / 10 oz. microbrew / 8 oz. malt liquor
4 oz. of wine
1 oz. of hard alcohol (regular shot glass)

	Su	M	T	W	T	F	Sa
Number of drinks							
Number of hours							

Think of the occasion that you drank the most in the **past month**. How much did you drink?___ How many hours did you drink?____

If applicable, other substances used ____

____

SECTION IV: (continued)

Do you use alcohol or drugs to (check all that apply): Manage stress?__ To relax?__ To change mood?__ For sleep?__

How often do you gamble? (please mark one response)
□ Never □ Once a Year □ 2 to 3 Times a Year □ Every Other Month □ Once a Month □ 2 to 3 Times a Month □ Weekly
□ More Than Once a Week □ Every Other Day □ Every Day

How much time outside of academic work do you spend on the internet per day? (please mark one response)
□ 0-1hr □ 2-3hrs □ 4-6hrs □ 7-9hrs □ 10+

SECTION V: FAMILY OF ORIGIN INFORMATION

	Age	Name	Occupation	Deceased (Y/N)
Parent/Guardian	_______	____________________________	___________________________	____
Parent/Guardian	_______	____________________________	___________________________	____
If applicable:				
Stepparent	_______	____________________________	___________________________	____
Stepparent	_______	____________________________	___________________________	____
Siblings	_______	____________________________	___________________________	____
	_______	____________________________	___________________________	____
	_______	____________________________	___________________________	____
If applicable:			Living with you? (Y/N/Part time)	
Partner/Spouse(s)	_______	______________________________	______________________	_______
	_______	______________________________	______________________	_______
Children	_______	______________________________	______________________	_______
	_______	______________________________	______________________	_______

Are your parents divorced? Yes _____ No _____

Have any members of your family had problems with:

drugs ___ alcohol ___ depression ___ anxiety ___ other mental illness ___ diabetes ___ epilepsy ___

Problem	Who	Current Y / N	Past Y / N

Among your friends and family, whom do you count on for support? ____

____

Are you: Single ___ Dating ___ Married / Partnered ___ Divorced / Unpartnered ___ Widowed / a surviving partner ___

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

Major Problems | Minor problems | Satisfactory | Very satisfactory

How long have you been in the relationship? ______________________________________

Is there anything else we need to know to assist you? Please ask for an extra sheet of paper if needed.