



**BEHAVIORAL  
HEALTH**

228 N Cherry St, Building B  
Fruita, CO 81521  
Phone: (970) 858-2527  
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## **NEUROPSYCHOLOGICAL AND PSYCHOSOCIAL HISTORY QUESTIONNAIRE**

### **INSTRUCTIONS**

1. You have been referred to this office for neuropsychological consultation and/or testing. The purpose of this appointment (and any tests that may be administered if recommended by the provider) is to make an assessment of changes, impairments, or problems in your mental abilities (sometimes referred to as cognitive functions) and in your mood, emotions, or behavior that may have resulted from a brain injury or brain dysfunction. This questionnaire includes items that relate to the reason(s) you were referred and to the types of difficulties you may have been having. Your answers to these questions will help the provider better understand the nature and effects of your brain injury or dysfunction and will help with evaluation and treatment planning.
2. This new patient paperwork must be completed before an appointment can be scheduled. You can return this paperwork by fax or in-person. You may also mail it to our hospital mailing address at Behavioral Health Dept, Family Health West, PO Box 130, Fruita, CO 81521. If you prefer, an electronic version on our website is also available.
3. Some of the questions are of a sensitive or personal nature. The provider and office staff will safeguard your privacy in compliance with current legal and ethical standards and will release information only to other professionals whom you have authorized and for whom you have signed consent. This may include referring providers, schools, courts, insurers, or other agencies with appropriate authorization. Please note that there are limitations to confidentiality when your safety or the safety of others may be compromised, and you can discuss any questions you might have about this with your provider.
4. Read each of the items carefully and answer honestly. If you are not certain of an answer, please give your best response. Be aware that your answers may be compared with information obtained from other medical records.
5. Some items may ask for information that you have already answered on this or on other medical forms or questionnaires. We apologize for the repetitiveness. Please answer these items anyway.
6. If an item seems unclear or if you have questions, you may make a notation on the questionnaire or ask the provider directly.
7. Thank you for your cooperation in filling out this form accurately and completely.

# Section 1 Identifying Information

## Patient Information

**Patient's Legal Name:** \_\_\_\_\_ **SSN:** \_\_\_\_\_

**Patient's Preferred Name (Nickname)** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Legal Sex:**  Male  Female **Sex Assigned at Birth:**  Male  Female  Choose not to disclose

**Sexual Orientation:**  Straight/ Heterosexual  Gay  Lesbian  Bisexual  Choose not to disclose  
 Other: \_\_\_\_\_

**Gender Identity:**  Male  Female  Transgender Male  Transgender Female  Choose not to disclose  
 Other: \_\_\_\_\_

**Address:** \_\_\_\_\_ **Home Phone:** \_\_\_\_\_

**City:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_

**State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_ **Mobile:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_  No Email  Access to MyChart Portal

### Communication Preferences

I choose the following methods as my preferred communication methods for the options below:

<b>To Do:</b> <i>Tasks to help with your treatment plans and health goals</i>	<input type="checkbox"/> Mail	<input type="checkbox"/> Phone Call	<input type="checkbox"/> Text	<input type="checkbox"/> Email	<input type="checkbox"/> MyChart
<b>FHW News and Information:</b> <i>Information from your Healthcare Provider</i>	<input type="checkbox"/> Mail	<input type="checkbox"/> Phone Call	<input type="checkbox"/> Text	<input type="checkbox"/> Email	<input type="checkbox"/> MyChart
<b>Account Updates:</b> <i>Account management and account alerts</i>	<input type="checkbox"/> Mail	<input type="checkbox"/> Phone Call	<input type="checkbox"/> Text	<input type="checkbox"/> Email	<input type="checkbox"/> MyChart
<b>Telehealth Visit Alerts/ Reminders:</b>	<input type="checkbox"/> Mail	<input type="checkbox"/> Phone Call	<input type="checkbox"/> Text	<input type="checkbox"/> Email	<input type="checkbox"/> MyChart
<b>Appointment Notifications:</b>	<input type="checkbox"/> Mail	<input type="checkbox"/> Phone Call	<input type="checkbox"/> Text	<input type="checkbox"/> Email	<input type="checkbox"/> MyChart
<b>Billing Updates:</b>	<input type="checkbox"/> Mail	<input type="checkbox"/> Phone Call	<input type="checkbox"/> Text	<input type="checkbox"/> Email	<input type="checkbox"/> MyChart
<b>Health Record Notifications/ Updates:</b>	<input type="checkbox"/> Mail	<input type="checkbox"/> Phone Call	<input type="checkbox"/> Text	<input type="checkbox"/> Email	<input type="checkbox"/> MyChart
<b>FHW Updates and Messages:</b> <i>Receive updates from the FHW Organization</i>	<input type="checkbox"/> Mail	<input type="checkbox"/> Phone Call	<input type="checkbox"/> Text	<input type="checkbox"/> Email	<input type="checkbox"/> MyChart

### Additional Demographics:

**Marital Status:**  Single  Significant Other  Married  Common Law  Divorced  Legally Separated  
 Widowed  Patient Refused

**Religion:**  Catholic  Christian  Church of Jesus Christ of Latter-Day Saints  Orthodox Jew  
 Jehovah's Witness  None  Patient Refused  Other: \_\_\_\_\_

**Ethnicity:**  Mexican, Mexican American, or Chicano/a  Non-Hispanic  Other Hispanic, Latino/a, or Spanish origin  
 Patient Refused

**Race:**  White or Caucasian  Native American  Alaskan Native American  Black or African American  Asian  
 Patient Refused  Other: \_\_\_\_\_

**Preferred Pharmacy:**

- City Market Orchard Mesa
- City Market Clifton
- City Market N 12th Street
- City Market 24 Road
- City Market Fruita
- Other: \_\_\_\_\_

- Walgreens West Park Dr.
- Walgreens Clifton
- Walgreens North Ave
- Walgreens Fruita
- Target (CVS) Hwy 6 and 50

- Walmart Rimrock Ave
- Walmart North Ave
- Walmart Warrior Way
- Safeway Horizon Dr.
- Safeway F Rd

**Preferred Spoken Language:**  English  Spanish  Other: \_\_\_\_\_

**Preferred Written Language:**  English  Spanish  Other: \_\_\_\_\_

**Language and Interpreter Info: Need Interpreter?**  No  Yes

**Hard of Hearing?**  No  Yes

**Low Vision?**  No  Yes

**Additional Patient Information:**

Employment Status:  Disabled  Full Time  Not Employed  On Active Military Duty  Part Time

Previous Employer  Retired  Self Employed  Student – Full Time  Student – Part Time

Employer: \_\_\_\_\_ Employment Date: \_\_\_\_\_

Occupation: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

**Patient’s Emergency Contact:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

DOB: \_\_\_\_\_ Legal Guardian:  Yes  No Emergency Contact:  Yes  No

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Preferred Phone:  Home  Mobile Number: \_\_\_\_\_

Preferred Written Language: \_\_\_\_\_ Preferred Spoken Language: \_\_\_\_\_

Interpreter needed?  Yes  No Notify on Admission?  Yes  No

Authorized to receive letters about patient?  Yes  No

Authorized to have MyChart Proxy?  Yes  No

***If you would like us to be able to speak to another party about your appointments and account, please list***

Name: \_\_\_\_\_ Phone#: \_\_\_\_\_

**Patient Care Team:**

Primary Care Provider: \_\_\_\_\_

Office: \_\_\_\_\_

Receive Notifications about Admissions?  Yes  No

Receive Result Notifications?  All Results  Abnormal results only  No results

## Section 2 Presenting Problems and Concerns

*The following items relate to the reason or reasons why you are seeking behavioral health support.*

Who referred you or recommended that you make the appointment? \_\_\_\_\_

Briefly describe the problem(s) that prompted you to come in at this time:

\_\_\_\_\_

1. Did you suffer an ***injury or trauma*** to the head or neck (for example, hurt your head in an automobile accident or fall or were struck in the head by an object)?  Yes  No (If "No," skip to #2 below.)

If "Yes," briefly describe what happened: \_\_\_\_\_

\_\_\_\_\_

When did the injury occur? \_\_\_\_\_ Where were you at the time? \_\_\_\_\_

Did you lose consciousness?  Yes  No If "Yes," for how long? \_\_\_\_\_

Were you hospitalized?  Yes  No If "Yes," where? \_\_\_\_\_ How long? \_\_\_\_\_

Which of the following did you experience as a result of the injury?

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Skull fracture                    | <input type="checkbox"/> Bleeding in the brain | <input type="checkbox"/> Penetrating head wound |
| <input type="checkbox"/> Contusion (bruising of the brain) | <input type="checkbox"/> Coma                  | <input type="checkbox"/> Paralysis              |

Did you have amnesia (inability to recall) after the injury?  Yes  No If "Yes," how long? \_\_\_\_\_

Did you have neurosurgery (brain surgery) after the injury?  Yes  No

If "Yes," what was this for? \_\_\_\_\_ Who was the surgeon? \_\_\_\_\_

Did you have any imaging (MRI or CT scan) of the brain?  Yes  No

If "Yes," what were the findings? \_\_\_\_\_

Which of the following rehabilitation therapies, if any, did you participate in for the above injury:

<input type="checkbox"/> Physical therapy	<input type="checkbox"/> Speech therapy	<input type="checkbox"/> Occupational therapy	<input type="checkbox"/> Psychological therapy
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2. Have you suffered any of the following ***illnesses, infections, or other conditions*** that involve the brain:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Stroke                     | <input type="checkbox"/> TIA (small stroke)        | <input type="checkbox"/> Brain tumor          |
| <input type="checkbox"/> Meningitis                 | <input type="checkbox"/> Encephalitis              | <input type="checkbox"/> West Nile virus      |
| <input type="checkbox"/> Lyme disease               | <input type="checkbox"/> Toxic chemical exposure   | <input type="checkbox"/> Heavy metal exposure |
| <input type="checkbox"/> Alcohol poisoning          | <input type="checkbox"/> Carbon monoxide poisoning | <input type="checkbox"/> Multiple sclerosis   |
| <input type="checkbox"/> Arteriovenous malformation | <input type="checkbox"/> Aneurysm                  | <input type="checkbox"/> Cerebral palsy       |
| <input type="checkbox"/> Chiari malformation        | <input type="checkbox"/> Hydrocephalus             | <input type="checkbox"/> ADD or ADHD          |
| <input type="checkbox"/> Guillain-Barre syndrome    | <input type="checkbox"/> Tourette's syndrome       | <input type="checkbox"/> Parkinson's disease  |

For any of the above that you have checked, briefly describe the condition or syndrome: \_\_\_\_\_

\_\_\_\_\_

Were you hospitalized for any of the above conditions?  Yes  No

If "Yes," where? \_\_\_\_\_ How long? \_\_\_\_\_

Have you had neurosurgery for any of the above conditions?  Yes  No If "Yes," when? \_\_\_\_\_

Which of the following rehabilitation therapies, if any, did you participate in for the above conditions:

<input type="checkbox"/> Physical therapy	<input type="checkbox"/> Speech therapy	<input type="checkbox"/> Occupational therapy	<input type="checkbox"/> Psychological therapy
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3. Have you been **diagnosed with or suspected of having dementia** (such as Alzheimer's, Lewy body, or multi-infarct dementia) or have you had mental changes from **other or unknown causes**?  Yes  No  
If "Yes," briefly describe what has been happening: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you been evaluated and/or treated by a neurologist or neurosurgeon?  Yes  No  
If "Yes," who? \_\_\_\_\_ When? \_\_\_\_\_

Which of the following rehabilitation therapies, if any, have you participated in:

<input type="checkbox"/> Physical therapy	<input type="checkbox"/> Speech therapy	<input type="checkbox"/> Occupational therapy	<input type="checkbox"/> Psychological therapy
---	---	---	--

**As a result of the event or condition(s) you reported above** (for #s 1, 2, or 3), which of the following cognitive symptoms, if any, have you experienced?

- |  |   |
|--|---|
| <input type="checkbox"/> Short-term memory problems (difficulty remembering new information) | <input type="checkbox"/> Word substitution problems       |
| <input type="checkbox"/> Long-term memory problems (difficulty remembering old information)  | <input type="checkbox"/> Problems expressing yourself     |
| <input type="checkbox"/> Word finding problems   | <input type="checkbox"/> Problems reading                 |
| <input type="checkbox"/> Problems comprehending  | <input type="checkbox"/> Problems writing or spelling     |
| <input type="checkbox"/> Problems with arithmetic  | <input type="checkbox"/> Problems focusing                |
| <input type="checkbox"/> Problems retaining what you read                                    | <input type="checkbox"/> Problems multitasking            |
| <input type="checkbox"/> Problems concentrating  | <input type="checkbox"/> Weakness or numbness             |
| <input type="checkbox"/> Problems planning or organizing                                     | <input type="checkbox"/> Sensitivity to light or noise    |
| <input type="checkbox"/> Becoming disoriented  | <input type="checkbox"/> Loss of balance or equilibrium   |
| <input type="checkbox"/> Changes in your senses of smell or taste                            | <input type="checkbox"/> Loss of gross motor coordination |
| <input type="checkbox"/> Difficulty walking  |   |
| <input type="checkbox"/> Loss of fine motor coordination                                     |   |

**As a result of the event or condition(s) you reported above**, which of the following personality or emotional symptoms, if any, have you experienced?

- |  |  |
|--|--|
| <input type="checkbox"/> Mood changes                            | <input type="checkbox"/> Irritability or impatience        |
| <input type="checkbox"/> Impulsivity                             | <input type="checkbox"/> Poor judgment                     |
| <input type="checkbox"/> Lack of empathy (sensitivity to others) | <input type="checkbox"/> Withdrawal/self-isolation         |
| <input type="checkbox"/> Anxiety or unusual fears                | <input type="checkbox"/> Depression                        |
| <input type="checkbox"/> Seeing things that are not there        | <input type="checkbox"/> Hearing things that others do not |

**Medications:** Do you **currently** take medicines that could affect the brain, such as:

- Pain medication (Please list) \_\_\_\_\_
- Sedatives (Please list) \_\_\_\_\_
- Psychiatric medicines (Please list) \_\_\_\_\_
- Heart medicines (Please list) \_\_\_\_\_
- Other medicines (Please list) \_\_\_\_\_

**The following items pertain to events or conditions that occurred prior to the injury or illness that prompted you to come to the office at this time.**

**Have you ever previously** (Please check all that apply and give the date, if known):

- |  |   |
|--|---|
| <input type="checkbox"/> Had a concussion  | <input type="checkbox"/> Been knocked out           |
| <input type="checkbox"/> Had a “whiplash” injury   | <input type="checkbox"/> Been in a coma             |
| <input type="checkbox"/> Had a closed head injury  | <input type="checkbox"/> Had bleeding in the brain  |
| <input type="checkbox"/> Had a skull fracture  | <input type="checkbox"/> Had penetrating head wound |
| <input type="checkbox"/> Been deprived of oxygen (such as a near drowning or asphyxiation) |   |

**Have you ever** (Please check all that apply and give the date, if known):

- |  |   |
|--|---|
| <input type="checkbox"/> Had a seizure/convulsion                    | <input type="checkbox"/> Had a small stroke (TIA) |
| <input type="checkbox"/> Had a major stroke                          | <input type="checkbox"/> Had a brain tumor        |
| <input type="checkbox"/> Been treated for epilepsy                   | <input type="checkbox"/> Had Tourette’s Syndrome  |
| <input type="checkbox"/> Had brain surgery                           |   |
| <input type="checkbox"/> Had severe and prolonged fever (above 104°) |   |

**Have you ever been diagnosed or treated for** (Please check all that apply and give the date, if known):

- |   |   |
|---|---|
| <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Hypoglycemia                                 |
| <input type="checkbox"/> Lupus                    | <input type="checkbox"/> Hypothyroidism                               |
| <input type="checkbox"/> Chronic fatigue syndrome | <input type="checkbox"/> Fibromyalgia                                 |
| <input type="checkbox"/> Heart disease            | <input type="checkbox"/> Chronic obstructive pulmonary disease (COPD) |
| <input type="checkbox"/> Sleep apnea              |   |

**Have you ever** (Please check all that apply and give the date, if known):

- |  |                                       |
|--|---------------------------------------|
| <input type="checkbox"/> Abused alcohol  | <input type="checkbox"/> Used tobacco |
| <input type="checkbox"/> Abused recreational drugs (such as marijuana, cocaine, meth)  |                                       |
| <input type="checkbox"/> Abused inhalants (such as gasoline or glue)   |                                       |
| <input type="checkbox"/> Abused prescription drugs (such as pain pills, sedatives, stimulants)   |                                       |
| <input type="checkbox"/> Been exposed to neurotoxins (substances that can be harmful to the brain such as pesticides, industrial solvents, or poisonous fumes) _____ |                                       |
| <input type="checkbox"/> Been exposed to heavy metals (such as lead or mercury)  |                                       |
| <input type="checkbox"/> Been exposed to toxic gases (such as carbon monoxide or hydrogen sulfide)   |                                       |

**Have you ever been diagnosed or treated for** (Please check all that apply):

- |  |  |
|--|--|
| <input type="checkbox"/> Learning disabilities | <input type="checkbox"/> Autism spectrum disorder                              |
| <input type="checkbox"/> Developmental delays  | <input type="checkbox"/> Genetic disorders (such as Fragile X or Klinefelters) |
| <input type="checkbox"/> Cerebral palsy        | <input type="checkbox"/> Spina bifida  |

## Section 3

### Mood, Emotional, or Behavioral Concerns

Please check any of the symptoms listed below that you have experienced in the **last 6 months**:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Depression                | <input type="checkbox"/> Mood swings       | <input type="checkbox"/> Obsessive thoughts        |
| <input type="checkbox"/> Discouragement            | <input type="checkbox"/> Racing thoughts   | <input type="checkbox"/> Compulsive behaviors      |
| <input type="checkbox"/> Frustration               | <input type="checkbox"/> Excessive energy  | <input type="checkbox"/> General anxiety           |
| <input type="checkbox"/> Persistent unhappiness    | <input type="checkbox"/> Insomnia          | <input type="checkbox"/> Social anxiety            |
| <input type="checkbox"/> Helplessness              | <input type="checkbox"/> Impatience        | <input type="checkbox"/> Nightmares                |
| <input type="checkbox"/> Hopelessness              | <input type="checkbox"/> Irritability      | <input type="checkbox"/> Flashbacks                |
| <input type="checkbox"/> Low self-worth            | <input type="checkbox"/> Agitation/anger   | <input type="checkbox"/> Exaggerated startle       |
| <input type="checkbox"/> Crying spells             | <input type="checkbox"/> Distractibility   | <input type="checkbox"/> Feeling disconnected      |
| <input type="checkbox"/> Loss of pleasure/interest | <input type="checkbox"/> Impulsivity       | <input type="checkbox"/> Gambling problems         |
| <input type="checkbox"/> Thoughts of death         | <input type="checkbox"/> Risk taking       | <input type="checkbox"/> Computer addiction        |
| <input type="checkbox"/> Self-harmful behaviors    | <input type="checkbox"/> Hyperactivity     | <input type="checkbox"/> Problems with pornography |
| <input type="checkbox"/> Loneliness                | <input type="checkbox"/> Confusion         | <input type="checkbox"/> Eating problems           |
| <input type="checkbox"/> Withdrawal/Isolation      | <input type="checkbox"/> Memory problems   | <input type="checkbox"/> Alcohol/drug use          |
| <input type="checkbox"/> Grief                     | <input type="checkbox"/> Judgment problems | <input type="checkbox"/> Suspicion/paranoia        |
| <input type="checkbox"/> Guilt/shame               | <input type="checkbox"/> Excessive worry   | <input type="checkbox"/> Hearing voices            |
| <input type="checkbox"/> Lack of motivation        | <input type="checkbox"/> Panic attacks     | <input type="checkbox"/> Visual hallucinations     |
| <input type="checkbox"/> Feeling overwhelmed       | <input type="checkbox"/> Phobias           | <input type="checkbox"/> Other disturbing thoughts |

Have you had problems with your sleep?  Yes  No If "Yes," indicate which:

- |  |   |
|--|---|
| <input type="checkbox"/> Sleeping more than normal | <input type="checkbox"/> Trouble falling asleep             |
| <input type="checkbox"/> Trouble staying asleep    | <input type="checkbox"/> Waking up early                    |
| <input type="checkbox"/> Sleep apnea               | <input type="checkbox"/> Feeling unrefreshed in the morning |

How long have these problems been going on? \_\_\_\_\_

Have you had problems with your energy during the day?  Yes  No If "Yes," indicate which:

- |   |   |
|---|---|
| <input type="checkbox"/> Fatigue                | <input type="checkbox"/> Little or no energy    |
| <input type="checkbox"/> More energy than usual | <input type="checkbox"/> Restlessness/agitation |

How long have these problems been going on? \_\_\_\_\_

Have you had problems with your appetite or eating patterns?  Yes  No If "Yes," indicate which:

- |  |   |
|--|---|
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Increased appetite |
|--|---|

How long have these changes been going on? \_\_\_\_\_

How much weight have you: Gained? \_\_\_\_\_ or Lost? \_\_\_\_\_

The term "mood" refers to one's overall sense of emotional well-being. On average, **over the last 6 months**, where would you rank your mood on a scale of 1 to 10 where 10 is best and 1 is worst? \_\_\_\_\_

Which, if any, of the following have been affected by the above mood or emotional difficulties?

- |  |  |  |                                   |
|--|--|--|-----------------------------------|
| <input type="checkbox"/> Handling everyday tasks | <input type="checkbox"/> Self esteem     | <input type="checkbox"/> Relationships | <input type="checkbox"/> Hygiene  |
| <input type="checkbox"/> Work/school             | <input type="checkbox"/> Housing         | <input type="checkbox"/> Legal matters | <input type="checkbox"/> Finances |
| <input type="checkbox"/> Recreational activities | <input type="checkbox"/> Sexual activity | <input type="checkbox"/> Parenting     | <input type="checkbox"/> Health   |

Have you **ever** had thoughts of, made statements about, threatened or attempted suicide?  Yes  No

If "Yes," please describe: \_\_\_\_\_

Have you **ever** engaged in self-harmful behavior (such as cutting or burning)?  Yes  No

If "Yes," please describe: \_\_\_\_\_

Have you **ever** had thoughts, made statements, or attempted to hurt someone else?  Yes  No

If "Yes," please describe: \_\_\_\_\_

### CURRENT STRESSORS

Please indicate any of the following that been causing problems with your mood or emotional adjustment **in the last 6 months**:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Relationship problems | <input type="checkbox"/> Family problems              | <input type="checkbox"/> Legal problems  |
| <input type="checkbox"/> Social problems       | <input type="checkbox"/> Occupational/school problems | <input type="checkbox"/> Health problems |

Have you experienced any significant losses or life changes **in the last year** (e.g. death of a family member or friend, job change, financial setback, relationship break-up, move, health problems, injury, or traumatic event)? If yes, please describe:

\_\_\_\_\_  
\_\_\_\_\_

### SUPPORT PERSONS AND RESOURCES

Please indicate any of the people or resources available to support you:

- |   |                                       |   |
|---|---------------------------------------|---|
| <input type="checkbox"/> Spouse/partner       | <input type="checkbox"/> Mother       | <input type="checkbox"/> Father               |
| <input type="checkbox"/> Other family members | <input type="checkbox"/> Friends      | <input type="checkbox"/> Healthcare providers |
| <input type="checkbox"/> Support groups       | <input type="checkbox"/> Church/faith | <input type="checkbox"/> Educational classes  |

Describe any coping skills or strategies you have learned from prior therapy, classes, self-help books, or other sources that are helping you now: \_\_\_\_\_

\_\_\_\_\_

What do you think are some of your top strengths? \_\_\_\_\_

\_\_\_\_\_

## Section 4 Mental Health History

*The following items pertain to mental health treatment you have received and mental health history for your family members.*

### MENTAL HEALTH PROVIDERS

Please list any other providers (prescribers, counselors/therapists, or psychologists) you are currently seeing or have previously seen. This would include individual, group, marriage or family counseling, as well as classes for domestic violence, anger management, or sexual offenses. Please list the most recent at the top.

Type of Treatment (e.g. medications, therapy)	Provider Name	Dates	Diagnosis/Reason

### PSYCHIATRIC MEDICATIONS

Please list medications you are **currently** taking.

Meant to Treat	Name of Medication	Dosage and Frequency	Prescribed by Whom
Depression			
Anxiety			
Mood stability			
Attentional deficits			
Psychosis			

Please list medications you **previously** took and no longer are taking.

Meant to Treat	Name of Medication	Dosage and Frequency	Prescribed by Whom
Depression			
Anxiety			
Mood stability			
Attentional deficits			
Psychosis			

Are you allergic to any medications? \_\_\_\_\_

Have you **ever** had any mood or emotional problems for which you were not treated?  Yes  No

If "Yes," please explain: \_\_\_\_\_

Have you **ever** been hospitalized in a mental health or psychiatric facility?  Yes  No

If "Yes," when: \_\_\_\_\_

Reason(s) for hospitalization: \_\_\_\_\_

### FAMILY HISTORY OF MENTAL HEALTH PROBLEMS

Please indicate family members (blood relatives only) who have been evaluated or treated for any of the following problems:

Problem	Family Members Affected
Hyperactivity/ADHD	
Depression	
Bipolar disorder	
Suicidal thoughts, attempts, or deaths	
Alcohol use disorder	
Drug use disorder	
Anxiety/panic disorder	
Obsessive-compulsive disorder	
Schizophrenia	
Criminal/legal convictions	
Dementia	
Developmental delay	

## Section 5

### Social and Developmental History

*The following items pertain to key relationships, your experiences growing up, and your education.*

#### FAMILY HISTORY

Where were you born? \_\_\_\_\_ Where were you mainly raised? \_\_\_\_\_

**While growing up**, where else did you live? \_\_\_\_\_

If you moved often while growing up, what were the reasons? \_\_\_\_\_

While you were growing up, what was your father's main occupation? \_\_\_\_\_

While you were growing up, what was your mother's main occupation? \_\_\_\_\_

Is your father still living?  Yes  No If "No," what was the cause of death? \_\_\_\_\_

Is your mother still living?  Yes  No If "No," what was the cause of death? \_\_\_\_\_

Did your parents separate or divorce?  Yes  No If "Yes," how old were you at the time? \_\_\_\_\_

If "Yes," who did you live with mostly?  Mother  Father

If "Yes," did mother remarry?  Yes  No Did father remarry?  Yes  No

Growing up, what was your relationship with your mother like? \_\_\_\_\_

Growing up, what was your relationship with your father like? \_\_\_\_\_

What was your relationship with your step-parent(s) like? \_\_\_\_\_

Number of "full" siblings: \_\_\_\_\_ Number of half siblings: \_\_\_\_\_ Number of step siblings: \_\_\_\_\_

What was your rank in birth order (oldest, next to youngest, 3<sup>rd</sup> of 5, etc.)? \_\_\_\_\_

What was growing up like for you? Please describe: \_\_\_\_\_

**While growing up**, did you experience any of the following? (Check all that apply).

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Emotional abuse      | <input type="checkbox"/> Parent alcohol abuse | <input type="checkbox"/> Poverty               |
| <input type="checkbox"/> Sexual abuse         | <input type="checkbox"/> Parent drug abuse    | <input type="checkbox"/> Multiple family moves |
| <input type="checkbox"/> Physical abuse       | <input type="checkbox"/> Parent illness       | <input type="checkbox"/> Homelessness          |
| <input type="checkbox"/> Parental neglect     | <input type="checkbox"/> Childhood trauma     | <input type="checkbox"/> Loss of a loved one   |
| <input type="checkbox"/> Violence in the home | <input type="checkbox"/> Foster placement     | <input type="checkbox"/> Teenage pregnancy     |

#### EDUCATION HISTORY

Did you graduate from high school?  Yes  No Approximate GPA (in high school) \_\_\_\_\_

If "No," what was the highest grade you completed? \_\_\_\_\_

If "No," did you finish a GED?  Yes  No At what age? \_\_\_\_\_

Any college classes, trade school, or certifications?  Yes  No In what field? \_\_\_\_\_

<input type="checkbox"/> Associate's Degree	Institution _____	Year _____	Major _____
<input type="checkbox"/> Bachelor's Degree	Institution _____	Year _____	Major _____
<input type="checkbox"/> Graduate Degree	Institution _____	Year _____	Major _____

Were you ever held back?  Yes  No Did you take special classes for learning problems?  Yes  No

Were you suspended or expelled?  Yes  No Take special classes for behavior problems?  Yes  No

Extracurricular activities (e.g. soccer, band, debate): \_\_\_\_\_

Are you currently attending school?  Yes  No If "Yes," where? \_\_\_\_\_

If "Yes," what is your field of study? \_\_\_\_\_

## MILITARY HISTORY

Have you been or are you currently in the military?  Yes  No (If "No," skip the following questions):  
 Branch: \_\_\_\_\_ How long did you serve? \_\_\_\_\_ Were you overseas?  Yes  No  
 Were you involved in combat?  Yes  No If "Yes," briefly explain: \_\_\_\_\_  
 What was your job title or military occupation specialty (MOS)? \_\_\_\_\_  
 Date of Discharge: \_\_\_\_\_ Type of Discharge: \_\_\_\_\_ Rank at Discharge: \_\_\_\_\_

## EMPLOYMENT HISTORY

What type of work have you done most of your adult life? \_\_\_\_\_  
 What other jobs have you held? \_\_\_\_\_  
 If employed, current employer: \_\_\_\_\_ Position: \_\_\_\_\_  
 Length of time in this position: \_\_\_\_\_ Job Duties: \_\_\_\_\_  
 Have you ever been disciplined or fired from a job for conduct problems?  Yes  No If "Yes," explain:  
 \_\_\_\_\_  
 If not currently employed, are you any of the following?  Retired  Home by choice  Disabled  
 If disabled, what is the reason for the disability: \_\_\_\_\_

Which of these benefits do you receive?  SSDI  SSI  Food Stamps  TANF  WIC  
 Workers Compensation  None  Other (please specify: \_\_\_\_\_)

## MARITAL / RELATIONSHIP HISTORY AND CHILDREN

Have you **ever** experienced feeling unsafe (physically or emotionally) in a relationship with a romantic partner?  
 Yes  No If yes, how long ago? \_\_\_\_\_  
 Are you **currently** in a relationship?  Yes  No If yes, how long has the relationship lasted? \_\_\_\_\_  
 How is the relationship? \_\_\_\_\_  
 Have you been married or had a live-in relationship **previously**?  Yes  No If "Yes," how many times? \_\_\_\_\_  
 Prior marriages/live-in relationships:

How long?	Reason relationship ended:
1 <sup>st</sup>	
2 <sup>nd</sup>	
3 <sup>rd</sup>	

Please list any children, including your relationship with them (e.g. biological, step-child, foster, adopted, deceased).

First Name	Relationship	Gender	Age

## Section 6 Medical History

*The following items pertain to physical health conditions and medications you are taking.*

Primary care provider: \_\_\_\_\_ Date of last physical/lab work: \_\_\_\_\_

Specialists you see (name/type): \_\_\_\_\_

Indicate which of the following medical conditions you have **ever** experienced:

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Chronic back pain	<input type="checkbox"/> Asthma	<input type="checkbox"/> Meningitis
<input type="checkbox"/> Autoimmune disease	<input type="checkbox"/> Recurring headaches	<input type="checkbox"/> COPD	<input type="checkbox"/> Encephalitis
<input type="checkbox"/> Acid reflux (GERD)	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Digestive problems	<input type="checkbox"/> Brain injury
<input type="checkbox"/> Sleep apnea	<input type="checkbox"/> Thyroid problems	<input type="checkbox"/> Rheumatoid arthritis	<input type="checkbox"/> Bowel disease
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Liver problems	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Bladder disease
<input type="checkbox"/> Heart disease	<input type="checkbox"/> Kidney problems	<input type="checkbox"/> Neurologic problems	<input type="checkbox"/> Cancer
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Circulatory problems	<input type="checkbox"/> Stroke	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Chronic fatigue	<input type="checkbox"/> Blood disease	<input type="checkbox"/> Seizure	
<input type="checkbox"/> Chronic joint pain	<input type="checkbox"/> Gallbladder disease	<input type="checkbox"/> Neuropathy	

Indicate any health issues for which you are **currently** being followed or treated medically:

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List **current** prescription medications:

Medication	Dosage	Frequency	Prescribed By

List any over-the-counter (OTC) medications/vitamins/supplements you regularly take:

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List any surgeries you have ever had:

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# Section 7

## Alcohol and Substance Use History

### ALCOHOL USE

*The following items pertain to your experiences with alcohol and other drugs.*

How often do you **currently** drink an alcoholic beverage?

- Never                       A few times a year                       1 or 2 times a month                       1 or 2 times a week  
 Several times a week                       Every day

If you drink now or previously drank, how old were you when you began drinking? \_\_\_\_\_

How old were you when you started drinking more regularly? \_\_\_\_\_

If you drink, what type of beverage do you prefer (beer, wine, mixed drinks, etc.)? \_\_\_\_\_

How often will you have 5 or more alcoholic drinks on a single day?

- Never                       A few times a year                       1 or 2 times a month                       1 or 2 times a week  
 Several times a week                       Every day

Has anything happened **in the past year**, as a result of drinking, that you regret?  Yes     No

If "Yes," please explain: \_\_\_\_\_

Have you **ever** had blackouts, withdrawal symptoms, or health problems (e.g. enlarged liver, seizures) associated with drinking?  Yes     No

If "Yes," please describe: \_\_\_\_\_

Have you **ever** had legal, social, or work problems (e.g. arrest for DUI, missed work, gotten into fights or lost friends) because of drinking?  Yes     No:

If "Yes," please describe: \_\_\_\_\_

Has anyone **ever** suggested that you drink too much or that you ought to cut back?  Yes     No

If "Yes," please describe: \_\_\_\_\_

Have you **ever** been diagnosed or suspected of alcohol abuse or dependence?  Yes     No

If "Yes," please describe: \_\_\_\_\_

If you **previously** drank alcohol but stopped drinking, when did you stop? \_\_\_\_\_

Why did you stop drinking? \_\_\_\_\_

### SMOKING AND NICOTINE PRODUCTS

Do you **currently** smoke cigarettes?  Yes     No

If "Yes," how often do you smoke? \_\_\_\_\_ How many cigarettes? \_\_\_\_\_

If you do not currently smoke, did you **previously** smoke cigarettes?  Yes     No

If "Yes," how often did you smoke? \_\_\_\_\_ How many cigarettes? \_\_\_\_\_

When did you stop? \_\_\_\_\_ Why did you stop? \_\_\_\_\_

Do you **currently** use smokeless tobacco (chew or snuff)?  Yes  No If "Yes," how often? \_\_\_\_\_

Did you **previously** use smokeless tobacco?  Yes  No If "Yes," how often? \_\_\_\_\_  
When did you stop? \_\_\_\_\_ Why did you stop? \_\_\_\_\_)

Do you use **currently** use nicotine in any other form (gum, patches, vapor pen, etc.)?  Yes  No  
If "Yes," please describe: \_\_\_\_\_

### OTHER SUBSTANCES

Do you **currently** use caffeine in any form (e.g., coffee, tea, Pepsi, Mountain Dew, etc.)?  Yes  No  
If "Yes," what do you drink? \_\_\_\_\_ How much? \_\_\_\_\_ How often? \_\_\_\_\_

Do you **currently** use marijuana in any form (e.g., edibles, CBD, smoking, etc.)?  Yes  No  
If "Yes," what do you use? \_\_\_\_\_ How much? \_\_\_\_\_ How often? \_\_\_\_\_

If you **previously** used marijuana but quit, how much did you use? \_\_\_\_\_  
When did you stop? \_\_\_\_\_ Why did you stop? \_\_\_\_\_

Which of the following drugs do you **currently** use?

Drug	Which Drugs?	Frequency of Use
Stimulants (e.g. cocaine, methamphetamine)		
Hallucinogens (e.g. MDMA, LSD, psilocybin)		
Opioids (e.g. narcotic prescriptions, heroin)		
Inhalants (e.g. nitrous oxide)		
Other		

Which of the following drugs did you **previously** use?

Drug	Which Drugs?	When Stopped & Why
Stimulants (e.g. cocaine, methamphetamine)		
Hallucinogens (e.g. MDMA, LSD, psilocybin)		
Opioids (e.g. narcotic prescriptions, heroin)		
Inhalants (e.g. nitrous oxide)		
Other		

Has anyone **ever** suggested or accused you of abusing or being addicted to drugs?  Yes  No  
If "Yes," please explain: \_\_\_\_\_

Do you **currently** use any of the following prescription medications?

<input type="checkbox"/> Narcotic pain medication	<input type="checkbox"/> Steroids	<input type="checkbox"/> Sedatives	<input type="checkbox"/> Sleep agents	<input type="checkbox"/> Anti-inflammatories
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Has anyone **ever** suggested or accused you of misusing, abusing, or being addicted to pain medication, or of “medication (drug) seeking”?  Yes  No

If “Yes,” please explain: \_\_\_\_\_

Please indicate any type of alcohol or substance abuse treatment you have **ever** had. This would include inpatient hospitalization, detox, outpatient individual or group therapy, drug or alcohol classes (court ordered or not), attendance at NA, AA or other support groups:

Type of treatment	When	Provider / Group	Duration	Reasons

## Section 8 Legal History

Have you **ever** been arrested for a misdemeanor or felony?  Yes  No

If "Yes," how many times? \_\_\_\_\_

Have you **ever** been convicted of a misdemeanor or felony?  Yes  No

If "Yes," for what charge(s) or charges: \_\_\_\_\_

Have you **ever** been incarcerated?  Yes  No

If "Yes," how many times? \_\_\_\_\_ Where were you incarcerated? \_\_\_\_\_

How long were you incarcerated, all together? \_\_\_\_\_

Are you **currently** involved in any divorce or child custody proceedings?  Yes  No

Have you **ever** been involved in a lawsuit?  Yes  No

If "Yes," please explain: \_\_\_\_\_

***Thank you for your patience in filling out this questionnaire! If you have answered all the questions, this is now complete.***

***Is there anything else you want us to know? If so, write some notes below.***