MENTAL HEALTH ASSESSMENT FORM

CONTACT INFORMATION

First Name_____Last Name_____

Parent/Guardian (if applic)_____

Birth Date_____/____/_____ Gender: □ Male □ Female

Address_____City_____State_____Zip_____

Cell/Other Phone_____Email_____

FAMILY BACKGROUND

1. Marital Status □ Married □ Divorced □ Single □ Committed Relationship □ Widowed
2. Number of children at home_____
3. Currently in foster care or not living with parent/s: □ Yes □ No □ Not applicable
3. Religious Beliefs: □ Christian/Denomination (if applic)_____
   □ Atheist □ Agnostic □ Other_____

HISTORY

1. Did you experience any of the following during your childhood years?

   □ Physical abuse □ Neglect □ Sexual abuse □ Other_____

2. Have you experienced any of the following during your adult years?

   □ Sexual abuse/sexual assault □ Domestic violence □ Loss of a close friend or relative

   □ Loss of a child or miscarriage Victim of a crime □ Military combat/war □ Other

How recent?_____

NOTES/COMMENTS:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

MENTAL HEALTH BACKGROUND

1. Has a health care professional diagnosed you with any mental health diagnosis? □ Yes □ No
   If so, what is/are the diagnosis:

   _____ _____
   _____ _____
   _____ _____

2. Have you worked with a counselor or psychiatrist before? □ Yes □ No
   Who_____When_____

MENTAL HEALTH (CONT.)

3. Do you take any mental health, prescription medication/s? □ Yes □ No
If so, what:

_____ Dose_____ For what_____
_____ Dose_____ For what_____
_____ Dose_____ For what_____

Who prescribes your medication/s? _____

MARK ANY FEELINGS, THOUGHTS & BEHAVIORS YOU HAVE NOTICED OR EXPERIENCED IN THE PAST 3 MONTHS:

□ Depression:
- □ Sadness
- □ Cry often
- □ Prefer to be alone, isolate self
- □ Negative thoughts
- □ Feel numb/foggy
- □ "Heavy" (dark cloud over self)
- □ Suicidal thoughts
- □ Cut/physically harm self
- □ Poor self-esteem/confidence
- □ Forgetful
- □ Lack motivation
- □ Feels hopeless or worthless
- □ Frequently tired/often nap
- □ Lack of appetite
- □ Turn to food/overeat
- □ No longer spend time with friends or family

□ Anxiety:
- □ Get panic attacks
- □ Afraid of new situations
- □ Anxious/avoid people
- □ Constant worry
- □ Excessive fear
- □ Feel people watching or talking about me frequently
- □ Anxiety effects ability to work
- □ Have repetitive behaviors
- □ Lights/noise bothers me
- □ Certain textures bother me
- □ Get fixated on things
- □ Get frustrated/agitated easily
- □ Struggle with anger/temper
- □ Cannot sleep or stay asleep
- □ Often feel dirty/unclean
- □ Thoughts/mind "will not stop"

□ Focus/Attention:
- □ Disorganized
- □ Easily distracted
- □ Problems completing things
- □ Need to be moving around
- □ Need to touch things
- □ Impulsive actions
- □ Need some noise to focus
- □ Often tapping finger/hands/legs, flicking, or other body stimulation movement
- □ Get in trouble at school or work with bothering others
- □ Often act before I think
- □ Get into fights
- □ Often lie/don't tell the truth
- □ Reckless/risk-taking choices

□ Adjustment/Stress/Life Change:
- □ Recently lost close friend/family
- □ Have new job or lost a job
- □ Recent marriage
- □ Recent relationship separation or divorce
- □ Placed in foster care/removed from home/family
- □ Recently experienced trauma and/or abuse
- □ Feel overwhelmed with life situation
- □ Currently homeless
- □ Fearful of being evicted/losing home
- □ Financial stress – do not have money to take care of needs
- □ Health/medical problems

□ Relationships/Sexual:
- □ Choose abusive/unhealthy relationships
- □ Frequent sexual partners
- □ Afraid of commitment and/or unfaithful in relationships
- □ Recently divorced or separated
- □ Struggle with anger and/or aggression in relationships
- □ Sexual addictions

□ Other Behaviors:
- □ Frequent/fast mood changes
- □ Obsessive thoughts
- □ Strong need for cleanliness
- □ Problems with honesty
- □ Do not eat/starve self

Other Behaviors (cont.):
- □ Over-eat and throw up
- □ Need things organized a certain way or get upset
- □ Repeat patterns (numbers, touching, words, behaviors)
- □ Uncontrollable spending
- □ Feel out-of-control frequently
- □ Do not care about others feelings or have remorse
- □ Hear or see things others cannot see or hear
- □ Problems with learning or understanding
- □ Problems with the law
- □ Get into fights easily
- □ Hurt animals on purpose
- □ Enjoy hurting other people

COMMENTS/NOTES:

_____
_____
_____
_____
_____
_____
_____
_____

HEALTH BACKGROUND

Do you have a primary physician? □ Yes □ No
Do you have any health/medical issues that affect your mental health/well-being? Please describe.

_____
_____

SUBSTANCE USE

1. Do you currently use any drugs/substances? □ Yes □ No
   If yes, what do you currently use:

   _____ _____
   _____ _____

2. When did start using any substances (if applic): _____

3. If using any substances, are you currently in any treatment program? □ Yes □ No
   If yes, with who:_____

SUPPORT SYSTEM

1. Who is a part of your positive support system?

   _____
   _____

NOTES/COMMENTS

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____