MERIDIAN BEHAVIORAL HEALTH

THERAPY QUESTIONNAIRE

NAME: _____ **DOB:** _____

LEGAL NAME, IF DIFFERENT: _____

GENDER IDENTITY: _____ **PRONOUNS:** _____

WHAT PROBLEM OR CONCERN BRINGS YOU HERE TODAY? _____

_____

_____

MENTAL HEALTH

ANY MENTAL HEALTH DIAGNOSES (depression, anxiety, ADHD, PTSD, etc.)? Y____ N____

If yes, please list: _____

_____

_____

OTHER MENTAL HEALTH CONCERNS (changes in mood, sleep, appetite, interest, etc.)? Y___ N___

If yes, please explain: _____

_____

ANY *SIGNIFICANT* PROBLEMS WITH ANXIETY (feeling really anxious, nervous, tense, fearful, panicked, scared, like bad things are going to happen, etc.)? Y___ N___

If yes, please describe: _____

_____

ANY *SIGNIFICANT* PROBLEMS WITH DEPRESSION (feeling really down, hopeless, etc)? Y___ N___

If yes, please describe: _____

_____

DO YOU HAVE ANY OTHER CONCERNS, SUCH AS COMPULSIVE GAMBLING, SEX OR INTERNET ADDICTION, COMPULSIVE SPENDING, OR AN EATING DISORDER? Y____ N____

If yes, please describe: _____

_____

DO YOU HAVE ANY HISTORY OF TRAUMA AS AN ADULT OR CHILD (ABUSE, ASSAULT, LIFE-THREATENING EVENTS, DEATH OF LOVED ONE, ETC)? Y____ N____

If yes, please describe: _____

_____

_____

HAVE YOU EVER HAD SUICIDAL THOUGHTS? Y____ N____

WHEN DID YOU LAST HAVE SUICIDAL THOUGHTS? _____

HAVE YOU EVER ATTEMPTED SUICIDE? Y ___ N ___ If yes, what date(s):_____

WHAT ARE YOUR ACTIVITIES/HOBBIES/INTERESTS?

_____

_____

HAVE YOU LOST INTEREST IN ANY OF THE ABOVE? Y____ N____

If yes, please describe: _____

_____

TREATMENT AND COUNSELING HISTORY

DO YOU CURRENTLY SEE A PSYCHIATRIST? Y____ N____ If yes, name: _____

DO YOU CURRENTLY SEE A COUNSELOR? Y____ N____ If yes, name: _____

LIST ALL COUNSELING/TREATMENT / PSYCHIATRIC HOSPITALIZATIONS: (most recent first)

Date	Type of Treatment/Length	Provider	Reason

HEALTH HISTORY AND CONCERNS

DESCRIBE ANY CURRENT/PAST PHYSICAL HEALTH CONCERNS (surgeries, illnesses, injuries, chronic pain,etc.):_____

_____

WHO IS YOUR PRIMARY CARE PHYSICIAN? _____

Phone:_____ **Address**: _____

OTHER PHYSICIANS PROVIDING CARE:

_____

ARE YOU CURRENTLY PREGNANT? Y____ N____ NOT APPLICABLE____

LIST ALL MEDICATIONS THAT YOU ARE TAKING (PRESCRIBED AND OVER THE COUNTER)

Name	Dosage	How often?	For how long?	Prescribed for?	Prescribing Physician

ALCOHOL, CIGARETTES, AND OTHER DRUG USE

Please circle the substances that you are currently using OR have used in the past, and describe usage.

Name	Used in past 12 months	Used over 12 months ago	Describe frequency/amount
Alcohol			
Cigarettes			
Marijuana			
Hallucinogens (LSD, acid, mushrooms)			
Club Drugs (Ecstasy, Molly, GHB)			
Amphetamines (Adderall, ADHD meds)			
Sedatives (Xanax, Valium, Benzodiazepines, Barbiturates)			
Opiates (Lortab, Percocet, Oxycodone, hydrocodone)			
Heroin			
Cocaine/Crack			
Methamphetamine			
Methadone			
Inhalants			

ANY HISTORY OF BLACKOUTS (unable to remember periods of time while using)? Y___ N___

IF YES, HOW MANY HAVE YOU HAD AND WHEN WAS THE LAST ONE?

_____

DO YOU HAVE A HISTORY OF EXPERIENCING ANY WITHDRAWAL SYMPTOMS (withdrawal symptoms occur when someone stops or significantly cuts back on using a substance)? Y____ N____
If yes, please describe (which substance caused withdrawal symptoms; what symptoms did you experience, such as seizures or others from the below list, using a different substance to avoid withdrawal symptoms, etc.)?

_____

_____

WHAT CONSEQUENCES HAVE YOU EXPERIENCED FROM YOUR ALCOHOL OR DRUG USE (legal, financial, educational, mental, spiritual, health, relationships, employment)?

_____

_____

LEGAL HISTORY

Date	Type/Offense	Outcome

FAMILY HISTORY

RELATIONSHIP STATUS: _____ **NUMBER OF LONG-TERM RELATIONSHIPS**: _____

DESCRIBE YOUR CURRENT RELATIONSHIP: _____

_____

DESCRIBE YOUR CURRENT LIVING ARRANGEMENT (what kind of housing you live in, how long you have lived there, who else lives there, any issues or difficulties): _____

_____

IS THERE A HISTORY OF MAJOR HEALTH CONCERNS IN YOUR FAMILY, INCLUDING MENTAL HEALTH ISSUES OR ADDICTIVE BEHAVIORS? Y___ N___

If yes, list their diagnosis and relationship to you: _____

_____

_____

_____

DESCRIBE YOUR FAMILY AND WHAT IT WAS LIKE GROWING UP IN YOUR FAMILY OF ORIGIN (How does/did your family get along? How does/did your family communicate and deal with conflict)?

_____

_____

WHO OF YOUR FAMILY AND FRIENDS ARE SUPPORTIVE?

_____

_____

EDUCATIONAL/ VOCATIONAL HISTORY

HIGHEST LEVEL OF EDUCATION/VOCATIONAL TRAINING COMPLETED:

_____

HAVE YOU EVER SERVED IN THE MILITARY? Y____ N____

ARE YOU CURRENTLY A STUDENT? Y____ N____ If yes, where? _____

DIFFICULTIES IN SCHOOL? _____

DESCRIBE YOUR CURRENT JOB STATUS (including length, satisfaction and any difficulties):

_____

_____

DESCRIBE YOUR FUTURE CAREER/LIFE GOALS:

_____

_____

DESCRIBE ANY IMPORTANT INFORMATION ABOUT YOUR CULTURAL CUSTOMS, RELIGION, GENDER IDENTITY, SEXUAL ORIENTATION, LANGUAGE, SOCIOECONOMIC STATUS, AND COUNTRY OF ORIGIN:

_____

_____

PERSONAL

WHAT ARE SOME OF YOUR PERSONAL STRENGTHS?

___ Good physical health ___ Average/above average intelligence ___Supportive family

___ Patient ___ Good self-care ___ Good self-esteem

___ Good verbal skills ___ Hard worker ___ Artistic

___ Maintains a job ___ Good insight into your own life ___ Determined

___ Good school functioning ___ Gets along well with others ___ Creative

___ Others: _____

RECENT SOURCES OF STRESS:

____ Legal Issues ____ Personal injury/illness ____Poor health

____ Problems at school ____ Financial problems ____ Death of a loved one

____ Recent hospitalization ____ Relationship breakup ____ Bullied/threatened

____ Issues with a family member ____ Parental discord ____ Social issues

____ Others: _____

WHAT ARE SOME POSSIBLE BARRIERS TO TREATMENT?

___ Low self-esteem ___ Family ___Poor judgment

___ Relationship interference ___ Transportation problems ___ Health problems

___ Financial problems ___ Below-average functioning ___ Limited insight

___ Low frustration tolerance ___ Trouble focusing

___ Others:_____

ANY OTHER INFORMATION YOU WOULD LIKE THE COUNSELOR TO KNOW?

_____

_____

_____

CLIENT SIGNATURE: _____ DATE: _____