DMC BEHAVIORAL HEALTH

Behavioral Health Information Form

Thank you for taking the time to complete this questionnaire. We will use this form at your initial intake appointment. It will help us to serve you better. Do not worry if you don't know the exact answers to all of the questions or if some answers don't apply.

Name:_____ DOB:_____ Date:_____

What are the reasons you have contacted Behavioral Health (or the reasons your PCP referred you)?

1. _____
2. _____
3. _____
4. _____

Do you have any of the following symptoms/issues? (Please check all that apply) If you find that any of these are particularly severe, please circle.

	Anxiety		Appetite Change		Hearing or seeing things
	Depressed Mood		Panic Attacks		Chronic Health Issues
	Poor Sleep		Memory Problems		Sleep Change
	Crying		Guilt		Inability to Concentrate
	Job Problems		School Problems		Relationship Conflict
	Legal Problems		School Problems		Financial Problems
	Grief/Loss		Irritability/Anger/Violence		Mania
	Changes in Sex Drive		Trauma/Abuse History		Sexuality/Gender Issues
	Eating Disorders		Medication no longer effective		

Previous Treatment

Have you ever been hospitalized for mental health reasons? If so, when and where?

_____

_____

Have you ever met with a counselor before? If so, when and where?

_____

_____

Was counseling helpful? Please state why or why not.

_____

_____

Have you ever been treated for an eating disorder (bulimia, anorexia, bingeing/purging)?

_____

_____

Have you ever been prescribed psychiatric medications (past and present)? If so, do you know the date of the prescription, who prescribed, and dosage? Any positive or negative effects?

- Medication:_____
- Medication:_____
- Medication:_____
- Medication:_____
- Medication:_____

Please feel free to attach any additional pages if you need, or you can discuss further medication history at your intake appointment

Have any members of your family ever received psychiatric treatment? Please provide details.

_____

_____

Please describe your current living situation (who you live with, etc.)

_____

_____

Safety Assessment

Have you ever had thoughts that you wanted to die?_____

Have you had these thoughts in the past 90 days?_____

Have you ever planned how you would die?_____

Do you have access to the methods for death?_____

Do you have access to firearms?_____

Have you ever harmed yourself on purpose (for example, cutting or burning)?

_____

Please list any Psychological Stressors (for example, a stressful job, recent breakup, caring for a sick loved one):

_____
_____
_____
_____

Childhood History

Please list all sibilings (Either by first name or gender) and if alive, their ages:

_____

_____

Education History

Highest grade (or college) completed:

_____

Any special services (IEP/504) or accommodations?

_____

Work History

Are you currently employed? If yes, Where?: _____

If not employed, are you on disability? _____

Position/Job Description:_____

How long have you been in this position? _____

Previous Work History:

_____

_____

Military Service History:

_____

_____

Current Family History

Are you? (Please circle) Married Single Separated Divorced Dating

Prior Relationship History:_____

_____

Have you had children? _____ Ages?_____

Legal History

Any history of jail/prison, convictions? _____

Any current legal problems? _____

Substance Abuse History (complete for all patients 18 and over)

Substance	Amount	Frequency	Duration	First Use	Last Use	Comments
Caffeine						
Tobacco						
Alcohol						
Marijuana						
Opioids/Narcotics						
Amphetamines						
Cocaine						
Hallucinogens						
Other						