Behavioral Health Comprehensive History

Name_____ Date_____

Check the best answer to each numbered symptom to indicate whether you have ever had problems related to it.

	In the past	Currently	Never
Your feelings and moods			
1. Depression	____	____	____
2. Mood swings	____	____	____
3. Nervousness	____	____	____
4. Panic attacks	____	____	____
5. Lack of motivation	____	____	____
6. Anger	____	____	____
7. Sadness	____	____	____
8. Guilt or shame	____	____	____
9. Feelings of impending doom	____	____	____
10. Feelings easily hurt	____	____	____
11. Feeling euphoric (high) or excessively energetic	____	____	____
12. Irritability	____	____	____
13. Restlessness	____	____	____
14. Boredom	____	____	____

Please write comments if you would like to clarify any answers in this section.

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Your thoughts	In the past	Currently	Never
1. Hopelessness	____	____	____
2. Worthlessness	____	____	____
3. Wishing you were dead	____	____	____
4. Hating yourself	____	____	____
5. Thinking you are a bad person	____	____	____
6. Thinking about killing yourself	____	____	____
7. Planning how to kill yourself	____	____	____
8. Believing people are out to get you	____	____	____
9. Being confused	____	____	____
10. Excessive worrying	____	____	____
11. Hating another person	____	____	____

	In the past	Currently	Never
12. Thinking about killing another person or people	____	____	____
13. Having delusions	____	____	____
14. Paranoia	____	____	____
15. Having obsessions	____	____	____
16. Phobias	____	____	____
17. Obsessing about sex	____	____	____
18. Hearing voices or sounds that others don‡ hear	____	____	____
19. Seeing things that others don‡ see	____	____	____
20. Excessively worrying about your health	____	____	____
21. Thinking you have let yourself down	____	____	____
22. Thinking you have let others down	____	____	____

Please write comments if you would like to clarify any answers in this section.

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How you feel physically	In the past	Currently	Never
1. Lack of energy	____	____	____
2. Poor appetite	____	____	____
3. Poor sleep	____	____	____
4. Disturbing dreams	____	____	____
5. Excessive sleep	____	____	____
6. Frequent headaches	____	____	____
7. Sex drive diminished or absent	____	____	____
8. Overweight	____	____	____
9. Frequent or constant pain	____	____	____
10. Chronic illness	____	____	____
11. Physical disability	____	____	____
12. Female problems	____	____	____
13. Frequent indigestion	____	____	____

Please write comments if you would like to clarify any answers in this section.

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Your behavior

	In the past	Currently	Never
1. Difficulty with the daily routine	____	____	____
2. Anger outbursts	____	____	____
3. Driving aggressively	____	____	____
4. Isolating yourself from others	____	____	____
5. Overeating	____	____	____
6. Overspending money	____	____	____
7. Drinking alcohol to excess	____	____	____
8. Using drugs	____	____	____
9. Getting arrested	____	____	____
10. Biting nails, pulling hair, or picking at your skin	____	____	____
11. Cutting or other self-injurious behavior	____	____	____
12. Hitting people or abusing animals	____	____	____
13. Attempting to control your weight through inducing vomiting, abusing laxatives, or exercising to excess	____	____	____
14. Restricting food intake	____	____	____
15. Gambling excessively	____	____	____
16. Spending too much time on the computer	____	____	____
17. Engaging in other compulsive behaviors	____	____	____
18. Sexual compulsivity	____	____	____
19. Attempts at suicide	____	____	____
20. Unable to concentrate	____	____	____
21. Memory problems	____	____	____
22. Unable to get organized	____	____	____
23. Unable to make or maintain friendships	____	____	____
24. Getting into fights	____	____	____

Please write comments if you would like to clarify any answers in this section.

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Your experience at work

	In the past	Currently	Never
1. Performing below your expectations or abilities	____	____	____
2. Unhappy at work	____	____	____
3. Frequently late	____	____	____
4. Frequently absent	____	____	____
5. Poor relationship with your boss	____	____	____

	In the past	Currently	Never
6. Poor relationships with coworkers	____	____	____
7. Find work boring	____	____	____
8. Feel unappreciated	____	____	____
9. Feel overworked	____	____	____
10. Feel underpaid	____	____	____
11. Feel insecure in your job	____	____	____
12. Unemployment	____	____	____
13. Military service	____	____	____
14. Public safety employment	____	____	____

Please write comments if you would like to clarify any answers in this section.

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Your personal life	In the past	Currently	Never
1. Death of friend or family member (including pets)	____	____	____
2. Financial problems	____	____	____
3. Conflict with your spouse or domestic partner	____	____	____
4. Relationship conflict	____	____	____
5. Conflict with former spouse	____	____	____
6. Victim of stalking or harassment	____	____	____
7. Conflict with your father	____	____	____
8. Conflict with your mother	____	____	____
9. Conflict with your children	____	____	____
10. Conflict with other relatives	____	____	____
11. Unsatisfactory housing	____	____	____
12. Law suit	____	____	____
13. Involvement with the criminal justice system	____	____	____
14. Not enough time for yourself	____	____	____
15. Too much time on your hands	____	____	____
16. Illness in the family	____	____	____
17. Addiction in the family	____	____	____
18. Other behavioral problems in the family	____	____	____
19. Other legal problems in the family	____	____	____
20. Sexual orientation issues	____	____	____
21. Religious or spiritual conflicts	____	____	____

Please write comments if you would like to clarify any answers in this section.

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Your family history

These questions apply to your blood relatives - Check all those that apply
Is there any family history of the following?

1. Depression ____
2. Excessive anxiety ____
3. Alcohol abuse ____
4. Drug abuse ____
5. Psychiatric hospitalization ____
6. Suicide or attempt at suicide ____
7. Hyperactivity ____
8. Problems with attention or concentration ____
9. Eating disorder ____
10. Violent behavior ____

Please write comments if you would like to clarify any answers in this section.

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Your history of drug and alcohol use

Check all appropriate columns for each drug or substance mentioned

	Never used	Past use	Past abuse	Current use	Current abuse
1. Alcohol	____	____	____	____	____
2. Marijuana	____	____	____	____	____
3. Cocaine	____	____	____	____	____
4. Methamphetamine	____	____	____	____	____
5. Heroin	____	____	____	____	____
6. Prescription opiates (for example, Oxycodone, Talwin, Hydrocodone, Morphine, codeine, Darvon, Ultram, Dilaudid, Fentanyl, Buprenorphine)	____	____	____	____	____

	Never used	Past use	Past abuse	Current use	Current abuse
7. Tranquilizers (for example, Xanax, Ativan, Klonopin, Valium, Librium)	____	____	____	____	____
8. Hallucinogenics (for example, LSD, mescaline, mushrooms)	____	____	____	____	____
9. Party drugs (for example, Ecstasy, GHB, Roofies)	____	____	____	____	____
10. Anabolic steroids	____	____	____	____	____
11. Sleeping pills (for example, Barbiturates, Quaalude, Ambien)	____	____	____	____	____
12. Inhalants (for example, hair spray, gasoline, solvents)	____	____	____	____	____
13. Muscle relaxants (Soma, Robaxin, others)	____	____	____	____	____
14. Others not mentioned above	____	____	____	____	____

Please write comments if you would like to clarify any answers in this section.

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Have you ever had a head injury with or without loss of consciousness? Yes___ No___. If yes, please give details_____
_____
_____

Have you ever been physically, sexually, or emotionally abused? Yes___ No___. If yes, please give details (if you are uncomfortable writing about this, this question can be explored at the time of the clinical interview.)_____
_____
_____

Has there recently been or do you anticipate a major change in your life circumstances, or are you faced with a major life decision at this time? Yes___ No___. If yes, please give details_____
_____
_____
_____

Is there a firearm in your home, or do you have access to one otherwise? Yes ___ No ___. If

yes, please give details._____

Have the police or the Department of Family and Children=s Services been to your home within the past year? Yes ___ No ___. If yes, please give details_____
_____
_____

Is physical or sexual abuse a current problem in your home? Yes ___ No ___. If yes, please give
details._____
_____
_____

Has physical or sexual abuse occurred in your home within the past year? Yes ___ No ___. If yes, please give details._____
_____
_____

Your psychiatric treatment history

1. Please list, including dates and reasons, all past psychiatric hospital or detox center admissions.

_____
_____
_____
_____

2. Other than the above, please list the names of all psychiatrists and other mental health professionals that you have seen, including the reason for treatment and approximate dates. Please include marriage or family counseling in this list, if applicable.

_____
_____
_____
_____

3. Please indicate, if you have been treated with medication for a psychiatric disorder in the past, the name of the medication, side effects you may have experienced, whether the medication was helpful, and approximate dates of use.

_____
_____
_____
_____

4. If you have ever participated in an out-patient therapy group, please indicate the therapist, approximate dates, reason for joining the group, and whether or not it was helpful.

_____
_____

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_____

5. If you have ever participated in a 12-step mutual help group, please indicate which group (AA, Al-Anon, GA, NA, etc.) you attended, whether it was helpful, and the approximate dates.

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_____

6. If there is anything else in your mental health history that you would like to mention, please indicate it here.

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7. Please indicate below, in your own words, why you are seeking a mental health/substance abuse evaluation and/or treatment at this time.

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_____
_____
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