OSU EAP Psychological Services

Mental Health History Form

Instructions: Please answer the questions below that are relevant to you and/or to the current situation that prompted you to seek counseling services.

Client Name: _____

Date: _____

Relationship Status: _____

Number of Children: _____

Employment Status/Position:_____

Referred by: _____

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Primary Reason for Seeking Service

Chief complaint (i.e., Depression, Anxiety, Relationship Problems, etc.)**:**

_____

What are your best hopes for a positive outcome if your situation improves? _____

_____

_____

Identify any goals/hopes you have for counseling: _____

_____

_____

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List CURRENT Distressing Symptoms (psychological, emotional, behavioral)

_____

_____

_____

Current eating habits:

How many meals (range/average) per day? _____

Have you had a change in appetite or weight – Yes/No? (If yes, describe) _____

_____

Current sleeping habits:

Sleep Disturbance: Yes/No? (If yes, describe) _____

How many hours (on average) of sleep per night? _____

Do you use a sleep aid (prescription, supplements) – Yes/No? (If yes, what?) _____

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PAST Mental Health History:

Provide information on any **past** distressing mental health symptoms and any treatments you tried/received (medication, counseling, in-patient treatment): _____

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CURRENT and PAST SUBSTANCE Use:

Caffeine: Yes/No? (If yes, describe) _____

Tobacco: Yes/No? (If yes, describe) _____

Alcohol: Yes/No? (If yes, describe) _____

Marijuana: Yes/No? (If yes, describe) _____

Prescription medications: (i.e., pain pills / opiates, stimulants, anti-anxiety, steroids, Adderall, other) – Yes/No? (If yes, describe) _____

Street drugs: (i.e., LSD, cocaine, ecstasy, meth, K-2, inhalants, heroin, other): – Yes/No? (If yes, describe) _____

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MEDICAL History: List past and present medical/health concerns or conditions.

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_____

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FAMILY History:

Family mental health conditions: Yes/No? (If yes, describe) _____

Family history of medical health conditions: Yes/No? (If yes, describe) _____

Family history of substance abuse/addictions: Yes/No? (If yes, describe) _____

Family history of abuse/trauma: Yes/No?

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Legal Problems: Yes/No? (If yes, describe) _____

Is there anything else the counselor needs to know about you or your situation?

_____

_____

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