MERIDIAN BEHAVIORAL HEALTH

THERAPY QUESTIONNAIRE

LEGAL NAME: _____ **TODAY'S DATE:** _____

PREFERRED NAME: _____ **DOB:**_____

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, please list 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

ARE YOU CURRENTLY SEEING A PSYCHIATRIST? Y____ N____

If yes, name: _____

ARE YOU CURRENTLY SEEING 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? _____

Address/City/State: _____

Phone:_____

OTHER PHYSICANS 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 AND OTHER DRUG USE

Please circle the substances that you are currently using OR have used in the past. Please describe your use and frequency of each drug in the space below.

Marijuana	Inhalants	Hallucinogens (LSD/Acid, mushrooms)
Cocaine/Crack	Over-the-counter medications	Club Drugs (Ecstasy, Molly, GHB)
Opiates (Lortab, Percocet, Oxycodone, hydrocodone)	Amphetamines (Adderall, Ritalin, other ADD/ADHD medications)	Sedatives (Xanax, Valium, other Benzodiazepines/ Barbiturates)
Heroin	Methamphetamine	Methadone

Other: _____

_____

_____

_____

_____

WHAT CHEMICALS HAVE YOU USED IN THE PAST 24 HOURS?

_____

_____

HOW MANY ALCOHOLIC DRINKS DO YOU CONSUME PER WEEK? _____ DO YOU SMOKE OR USE OTHER TOBACCO PRODUCTS? IF YES, DESCRIBE USE/HOW MANY CIGARETTES PER WEEK?

_____

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?

_____

HOW LONG WAS YOUR LONGEST PERIOD OF SOBRIETY AND WHEN WAS IT?

_____

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 WITHDRAWAL SYMPTOMS HAVE YOU EXPERIENCED IN THE PAST 7-14 DAYS?

___ Vomiting/nausea
___ Change in blood pressure
___ Tremors/shakes
___ Can't sleep or sleep a lot
___ Seizures
___ Muscle aches/cramps
___ Irritability
___ Fatigue/weakness
___ Anxiety
___ Tachycardia (rapid heart rate)
___ Diarrhea
___ Change in appetite
___ Slowing down of thoughts/movements
___ Hallucinations
___ Other _____

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

_____

_____

_____

HOW HAS YOUR ALCOHOL OR DRUG USE IMPACTED YOUR FAMILY OR SUPPORT SYSTEM?

_____

_____

RATE YOUR PROBLEM WITH DRUGS/ALCOHOL FROM 0-10 (0=no issue, 10=major issue): _____

WHAT ADDITIONAL INFORMATION DO YOU WANT THE COUNSELOR TO KNOW ABOUT YOUR ALCOHOL OR DRUG USE?

_____

_____

_____

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): _____

_____

_____

PLEASE LIST CHILDREN WITH NAMES AND AGES (if applicable):

_____

_____

FATHER'S NAME: _____

MOTHER'S NAME: _____

IS YOUR FATHER LIVING? Y____ N____ **IS YOUR MOTHER LIVING? Y____ N____**

LIST SIBLINGS BY FIRST NAME, AGE AND LOCATION:

_____

_____

IS THERE A HISTORY OF MAJOR HEALTH CONCERNS IN YOUR FAMILY? Y___ N___

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

_____

_____

LIST ANY MEMBERS OF YOUR FAMILY WHO HAVE HAD PROBLEMS WITH MENTAL HEALTH ISSUES OR ADDICTIVE BEHAVIORS: _____

_____

_____

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)?

_____

_____

_____

_____

_____

_____

EDUCATIONAL/ VOCATIONAL HISTORY

HIGHEST LEVEL OF EDUCATION/VOCATIONAL TRAINING COMPLETED:

_____

DEGREE/LICENSE/CERTIFICATION(S):

_____

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:

_____

_____

_____

_____

ETHNIC/CULTURAL INFLUENCE

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

_____

_____

_____

_____

SUPPORT SYSTEM

WHO OF YOUR FAMILY AND FRIENDS ARE SUPPORTIVE?

_____

_____

_____

PLEASE DESCRIBE YOUR SPIRITUALITY AND/OR RELIGION:

_____

_____

LEGAL HISTORY

(starting with most recent)

Date	Type/Offense	Outcome

ADDITIONAL LEGAL INFORMATION:

_____

_____

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

___ Poor judgment ___ Low frustration tolerance ___ Trouble focusing

___ Others:_____

_____

_____

OTHER INFORMATION YOU WOULD LIKE THE COUNSELOR TO KNOW:

_____

_____

_____

_____

_____

CLIENT SIGNATURE:

_____

DATE: _____

[COUNSELOR COMMENTS]:

_____

_____

_____

_____

_____

COUNSELOR NAME AND CREDENTIALS:

_____

COUNSELOR SIGNATURE AND CREDENTIALS:

_____

DATE: _____

[COUNSELOR, PLEASE UTILIZE THE COUNSELOR ADDENDUM FOR FINAL COMMENTS]