

SUMMIT CENTER FOR MENTAL HEALTH

Today's Date: _____

Name _____

Family History

Father: Living? Y N Date of Death _____ Cause: _____

Age: _____ Occupation: _____

Relationship as a child : Great Good OK Fair Poor

Relationship as an adult: Great Good OK Fair Poor

Mother: Living? Y N Date of Death _____ Cause: _____

Age: _____ Occupation: _____

Relationship as a child : Great Good OK Fair Poor

Relationship as an adult: Great Good OK Fair Poor

Step Parent:

Relationship as a child : Great Good OK Fair Poor

Relationship as an adult: Great Good OK Fair Poor

List Siblings and rate relationship

_____ : Great Good OK Fair Poor

_____ : Great Good OK Fair Poor

_____ : Great Good OK Fair Poor

_____ : Great Good OK Fair Poor

_____ : Great Good OK Fair Poor

(if you need more room for siblings, put the rest on the back of this page)

Religion: _____ Religion of Childhood _____

My childhood religious experience was Great Good OK Fair Poor None

Check all that are true from your childhood

Favoritism Physical Abuse Sexual Abuse Emotional Abuse

Parental Rages Religious Extremism I never felt good enough

Do you have a family history of:

Alcoholism Depression Schizophrenia Gambling Drug Abuse

Suicide attempts Suicide Mental Illness

Education

Did not graduate GED /High School Diploma Some College

Bachelor's Degree Advanced Degree

Marital History

Spouse's Name _____ Spouse's Age _____

Spouse's Occupation _____ Employer _____

How long have you been married. _____ ?

My marriage is Great Good OK Fair Poor

Number of marriages _____

Strength's of your present marriage

Problems of your present marriage

Employment

Employer: _____

Address: _____

City, State, Zip _____ Phone: _____

Your position _____ How long employed ? _____ years/months.

Do you find your work satisfying? Y N

What (if any) problems do you have with your employment?

Military Service? _____

Arrests Y N Convictions Y N

Check List- check all that apply

- Financial difficulties Legal Problems Depression Anxiety
- Voices in my head Suicidal thoughts Attempts Crying spells
- Difficulty with relationships Loneliness Anger Loss of appetite
- weight gain weight loss Eating disorder Self abuse Mood Swings
- Memory loss Agitation Mental Illness I have thought of hurting myself
- I have thought of hurting someone else Previous psychiatric hospitalization

Previous Mental Health Treatment

With whom? _____ When? _____ Helpful? Y N

Medications you are taking:

Anything else you think your therapist should know

The Summit Center for Mental Health

1. Do you feel you are a normal drinker? ("normal" – drink as much or less than most other people)

Circle Answer: YES NO

2. Have you ever awakened the morning after some drinking the night before and found you could not remember a part of the evening?

Circle Answer: YES NO

3. Does any near relative or close friend ever worry or complain about your drinking?

Circle Answer: YES NO

4. Can you stop drinking without difficulty after one or two drinks?

Circle Answer: YES NO

5. Do you ever feel guilty about your drinking?

Circle Answer: YES NO

6. Have you ever attended a meeting of Alcoholics Anonymous (AA)?

Circle Answer: YES NO

7. Have you ever gotten into physical fights when drinking?

Circle Answer: YES NO

8. Has drinking ever created problems between you and a near relative or close friend?

Circle Answer: YES NO

9. Has any family member or close friend gone to anyone for help about your drinking?

Circle Answer: YES NO

10. Have you ever lost friends because of your drinking?

Circle Answer: YES NO

11. Have you ever gotten into trouble at work because of drinking?

Circle Answer: YES NO

12. Have you ever lost a job because of drinking?

Circle Answer: YES NO

13. Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking?

Circle Answer: YES NO

14. Do you drink before noon fairly often?

Circle Answer: YES NO

15. Have you ever been told you have liver trouble such as cirrhosis?

Circle Answer: YES NO

16. After heavy drinking have you ever had delirium tremens (D.T.'s), severe shaking, visual or auditory (hearing) hallucinations?

Circle Answer: YES NO

17. Have you ever gone to anyone for help about your drinking?

Circle Answer: YES NO

18. Have you ever been hospitalized because of drinking?

Circle Answer: YES NO

19. Has your drinking ever resulted in your being hospitalized in a psychiatric ward?

Circle Answer: YES NO

20. Have you ever gone to any doctor, social worker, clergyman or mental health clinic for help with any emotional problem in which drinking was a part of the problem?

Circle Answer: YES NO

21. Have you been arrested more than once for driving under the influence of alcohol?

Circle Answer: YES NO

22. Have you ever been arrested, even for a few hours, because of other behavior while drinking?

Circle Answer: YES NO

(if Yes, how many times _____)

Alcohol & Drugs

At what age did you have your first drink? _____ At what age did you first try a drug? _____

Check any of the following that you have experimented with or used:

For each that you check, how often have you used and how much?

Barbiturates (downers) ___ Tranquilizers (Valium, Xanax, etc) ___ Sleeping Pills ___

Amphetamines (uppers) ___ Marijuana ___ Cocaine ___

Hallucinogens (LSD, STP, PCP) ___ Opiates (heroin, morphine, Demerol) ___

Ecstasy ___ Inhalants ___ other drugs ___ Over the counter medications ___