

Women's Wellness Center Mental Health Counseling Questionnaire

Barbara Bauer, PhD

Susan Murray, PhD

Laura McMurry, MSW, LCSW

Today's Date: _____

Full Name: _____ DOB: _____ Age: _____

GENERAL INFORMATION: (Check all that apply to you)

- Married Separated Single Divorced Widowed
 Disabled Employed Unemployed Student Retired

Educational Information:

Highest school grade completed (circle one) 8 9 10 11 12 years of college 1 2 3 4 advanced degree _____

Have you ever experienced learning difficulties or educational problems as a student? Yes No

EMPLOYMENT HISTORY:

	Type of work	Length of time	Feeling about job
Current job:	_____	_____	_____

HOUSEHOLD INFORMATION (check all that apply to you) In my home, I live with...

- Spouse Significant other Brother/sister Aunts/uncles Cousins
 Mother Father Foster parents Maternal Grandparents Paternal Grandparents
 Stepmother Stepfather Child(ren) Stepchildren
 Other (explain) _____

If you have children, how many do you have and what are their ages? _____

Medical History:

Are you currently on prescription medication? Yes No If yes, list meds: _____

If so, please list name and phone number of prescribing physician: _____

Have you ever had any serious medical problems? Yes No

If yes, describe the problem(s): _____

Have you ever experienced any of the following medical problems?

- Blackouts Shakes Manic episodes Head injury Hospitalization
 Nightmares Depression Panic attacks Compulsions/obsessions Addictive behavior
 Other (explain) _____

SOCIAL/EMOTIONAL INFORMATION: (check all that apply) I need help with...

- Parent/child conflict Not liking myself Feeling confused Eating disorder/weight loss
 Marital problems Being taken for granted Feeling lonely School/work performance
 Money problems Being sexually active Feeling angry or violent Smoking
 Poor communication Being overly sexually active Feeling tense/anxious Not sleeping
 Trauma Being sad or depressed Feeling like sex is a chore Dealing with legal authorities
 Self-esteem issue Being afraid Feeling unlovable Sexually transmitted disease
 Wanting to hurt myself, someone else or something Myself or family member abusing alcohol or drugs

ADDITIONAL INFORMATION: (Answer all that apply to you)

- Yes No Have you or any family member ever been affected by alcohol and/or drug abuse?
- Yes No Have you or any family member ever been addicted to prescription drugs?
- Yes No Have you been abused in any way? If so, How? _____
- Yes No Are you being abused now? If so, how and by whom? _____

SPIRITUAL INFORMATION:

- Is spirituality/religion a part of your life? Yes No
- If so, how is this relationship helpful to you? _____
- To which church do you claim membership? _____
- Active Moderate Inactive

Reasons for Seeking Services at this time:

How have you tried to solve this problem and how effective was it? _____

Have you previously participated in counseling, therapy, or psychological services? If so, please describe concerns, number of visits and approximate dates of those services.

Was it helpful? _____

Family Mental Health History:

LEGAL HISTORY:

If you have been in trouble with the authorities, please answer the following question:

Do you have any current legal issues pending? Explain: _____

MISSED APPOINTMENTS:

Please call at the earliest possible time to reschedule if you cannot keep your scheduled appointment. When a patient misses an appointment without notice, it is a waste of our counselor's valuable time, and also prevents her from being able to help another patient who might have been cared for during that scheduled time. Therefore, any patient who does not give at least 4 hours notice prior to missing a scheduled appointment will incur a \$60 fee, which must be paid before scheduling another appointment.

Please initial here to indicate you have read and understand the policy on missed appointments: _____