Comprehensive Psychological Services
Adult Mental Health History Form

Name_____ Date_____

Date of Birth ___/___/___Age ____ Gender _____Pronouns _____ Racial Identity_____

Describe briefly your present symptoms_____

Recent stressors (e.g., family, job, recent loss of loved one, financial issues): _____

Previous psychological evaluations:_____

Mental Health Services or Counseling (When? Where?) :_____

Psychiatric Hospitalizations (include where, when, & for what reason): _____

List ALL current prescription medications and how often you take them (if none, write none)

Medication Name Daily Dosage Estimated Start Date

List ALL past psychiatric prescription medications (if none, write none)

Medication Name Prescribed by: Taken when:

Current primary care provider:_____

Current medical problems: _____

Past medical problems, nonpsychiatric hospitalizations, and surgeries: _____

Concussions, loss of consciousness, or seizures: _____

Problems with sleep and/or appetite? : _____

Family Background and Childhood History

Where were you born & raised? _____

_____

By whom? _____

_____

Were you adopted? ( ) Yes ( ) No

List your siblings and ages: _____

_____

What was your father's occupation? _____

What was your mother's occupation? _____

Did your parents divorce? ( ) Yes ( ) No If so, how old were you when they divorced? _____

If they divorced, who did you live with? _____

Describe your father and your relationship with him: _____

_____

Describe your mother and your relationship with her: _____

_____

How old were you when you left home? _____

Has anyone in your immediately family died? _____

Who and when? _____

Any history of involvement with law enforcement? (specify) _____

_____

Were you ever the victim of abuse? ( ) Yes ( ) No

Extended family psychiatric problems past and present: (e.g., ADHD, depression, anxiety, learning disorders, autism) _____

_____

Developmental History

Any complications during your mother's pregnancy with you or your birth? (specify) _____

_____

Any health problems at birth or in infancy? (specify) _____

Any delays with walking/talking/toilet training? (specify) _____

Testing History

Performance on IQ/achievement testing: _____

History of hearing or speech/language abnormalities: _____

Ever receive occupational or physical therapy? (specify) _____

Educational History

Highest grade completed? _____ Where? _____

Did you attend college? _____ Where? _____ Major? _____

What is your highest educational level or degree obtained? _____

Did you ever repeat any grades? (specify) _____

Did you ever have academic accommodations? (specify) _____

Attention problems in school? (specify) _____

_____

Behavioral problems in school? Suspended or expelled? (specify) _____

_____

Occupational History

Are you currently:

( ) working ( ) student ( ) unemployed ( ) not working by choice ( )retired ( ) disabled

How long in your present position? _____

What is/was your occupation? _____

Where do you work? _____

Previous experience: _____

Future goals: _____

Relationship History and Current Family

Are you currently: ( ) Married ( ) Partnered ( ) Divorced ( ) Single ( ) Widowed

How long? _____

If not married, are you currently in a relationship? ( ) Yes ( ) No

Are you sexually active? ( ) Yes ( ) No

How would you identify your sexual orientation?

( ) straight/heterosexual ( ) lesbian/gay/homosexual ( ) bisexual

( ) unsure/questioning ( ) asexual ( ) other ( ) prefer to not answer

What is your spouse or significant other's occupation? _____

Describe your relationship with your spouse or significant other:_____

_____

Have you had any prior marriages? ( ) Yes ( ) No If so, how many? _____

Do you have children? ( ) Yes ( ) No If yes, list ages and gender: _____

_____

Describe your relationship with your children:_____

_____

List everyone who currently lives with you:_____

_____

Legal History

Have you ever been arrested? (specify)_____

_____

Do you have any pending legal problems? (specify)_____

_____

SUBSTANCE USE					
DRUG CATEGORY (circle each substance used other than those prescribed by a doctor and used exactly as prescribed)	Age when you first used this:	How much & how often did/do you use this?	How many years did you use or have you used this?	When did you last use this?	Do you currently use this?
TOBACCO: Cigarettes, Vapes, Cigars, chewing tobacco					Yes □ No □
ALCOHOL					Yes □ No □
CANNABIS: Marijuana, hashish, hash oil					Yes □ No □
STIMULANTS: Cocaine, crack					Yes □ No □
STIMULANTS: Methamphetamine—speed, ice, crank					Yes □ No □
AMPHETAMINES/OTHER STIMULANTS: Ritalin, Benzedrine, Dexedrine					Yes □ No □
BENZODIAZEPINES/TRANQUILIZERS: Valium, Librium, Halcion, Xanax, Diazepam, "Roofies"					Yes □ No □
SEDATIVES/HYPNOTICS/BARBITURATES: Amytal, Seconal, Dalmane, Quaalude, Phenobarbital					Yes □ No □
HEROIN					Yes □ No □
STREET OR ILLICIT METHADONE					Yes □ No □
OTHER OPIOIDS: Tylenol #2 & #3, 282'S, 292'S, Percodan, Percocet, Opium, Morphine, Demerol, Dilaudid					Yes □ No □
HALLUCINOGENS: LSD, PCP, STP, MDA, DAT, mescaline, peyote, mushrooms, ecstasy (MDMA), nitrous oxide					Yes □ No □
INHALANTS: Glue, gasoline, aerosols, paint thinner, poppers, rush, locker room					Yes □ No □
OTHER: specify)_____ _____ _____					Yes □ No □