**Baldwin Area Medical Center**
**Northwest Counseling Services**
**MENTAL HEALTH MEDICAL QUESTIONNAIRE - ADULT**

Name: _____ Birthdate: _____ Today's Date: _____
Primary Care Physician: _____ Medical Clinic: _____
Address: _____ City: _____ State/Zip: _____

1. May we contact your physician? _____ Yes _____ No

2. When was the last time you saw your physician? (date): _____

3. For what medical problems did you see your physician?: _____
_____

4. What medical problems, if any, are you currently having? _____
_____

5. Are those problems being treated?: _____ By Whom?: _____

6. What medications are you currently using? Please include over-the-counter medications as well as herbal supplements: _____
_____

7. List any medical problems that have been treated in the past.:_____
_____

8. Is there a family history of medical problems?: _____
_____

9. Is there a history of mental illness in your family? _____ Please describe _____
_____

10. Have you had any previous mental health treatment?: _____ If so, please list with whom, date(s) of treatment, for what problems, medications used with dosages and outcome of the treatment.: _____
_____
_____

11. Please list any hospitalizations, serious illnesses, or operations, including dates and where treated.: _____
_____

12. Do you have any hearing or sight loss, speech impairment, learning disability or other perceptual deficit/impairment? _____
_____

13. Do you use alcohol or drugs? _____ Type Used: _____
How Long? _____ Weekly Amount?: _____

14. Have you had any treatment for alcohol or drug problems?: _____ When?: _____
Where?: _____
Outcome of treatment: _____

15. Is there any family history of drugs or alcohol?: _____
_____

16. Is there anything else in your medical history that would be helpful for us to know?: _____
_____
_____

**RELATIONSHIPS:** ***(Please place an (x) on any items that apply to your self.)***

_____ Too few friends
_____ Regularly talks / play with friends
_____ Is overly shy
_____ Makes friends easily
_____ Others seem to be picking on my child
_____ Plays mostly with younger children
_____ Has enough friends
_____ Often gets into fights with friends
_____ Withdrawing from friends
_____ Finds it hard to keep friends
_____ Bullying or mean to friends
_____ Hangs out with a "bad" crowd

**SOURCE OF STRESS:** ***(Please list the things/events/problems that are creating stress for yourself at the present time.)***

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

**CURRENT FUNCTIONING**

***Place and (x) on the following scale to indicate how well you are coping with things at the present time. 100% mean you are coping the best you ever have.***

_____
0 10 20 30 40 50 60 70 80 90 100

**WHAT ARE YOUR GOALS IN COUNSELING**

***Please list the goals that you hope you will achieve in counseling. (Be as specific as you can.)***

1. _____
_____
2. _____
_____
3. _____
_____

**HOW MANY SESSIONS DO YOU THINK YOU WILL NEED?**

***Please place and (x) in the answer which best describes our expectations.***

_____ 1 – 3 sessions _____ 4 – 6 sessions _____ 7 – 9 sessions _____ 10 – 12 sessions
_____ Other (please specify how many sessions) _____

_____
Form Completed By (Signature) Date