STARKVILLE COUNSELING
ASSOCIATES

General Health and Mental Health Information:

Please circle below if you have had any of the following medical conditions

Angina	Arthritis	Asthma/Respiratory Problems	Chronis Headaches
Chronic Pain	Colitis/Crohn's	Diabetes	Head injury/Concussion
Heart Attack	High Blood Pressure	Hyperthyroidism	Hypothyroidism
Hysterectomy	Kidney Problems	Lupus	Menstrual Problems
Migraines	Miscarriage	PMS	Pregnancy
Seizures	Stomach Ulcers	Tuberculosis	Urinary Tract Infection

Please list any surgical procedures you have had done:_____

Please list any other medical problems not listed above:_____

Please list all psychotropic medications you are taking now or have EVER taken in the past:

Medication	Strength	Frequency	Date Started/Ended	Prescribed by

Family Mental Health History:

In the section below identify if you or a family member has a history of any of the following. If yes, please indicate the family member's relationship to you (father, grandmother, uncle, etc).

Substance/Disorder/Condition	Please Circle	List Family Member	Self
Alcohol/Substance abuse	YES NO		
Anxiety	YES NO		
Depression	YES NO		
Domestic Violence	YES NO		
Eating Disorders	YES NO		
Obesity	YES NO		
Obsessive Compulsive Disorder	YES NO		
Schizophrenia	YES NO		
Suicide Attempts	YES NO		
PTSD	YES NO		

How would you rate your current physical health?
POOR UNSATISFACTORY SATISFACTORY GOOD VERY GOOD

How would you rate your current sleep habits?
POOR UNSATISFACTORY SATISFACTORY GOOD VERY GOOD

Please indicate your average amount of sleep per day._____

How would you rate your current eating habits?
POOR UNSATISFACTORY SATISFACTORY GOOD VERY GOOD

Have you had a significant change in appetite recently? YES NO If yes, __increase __decrease

How many times per week do you generally exercise? _____

What types of exercises do you participate in?_____

Are you currently experiencing overwhelming sadness, grief or depression? YES NO If yes, for how long?_____

Are you currently experiencing anxiety, panic attacks or have any phobias? YES NO If yes, for how long?_____
If yes, explain_____

Have you ever been arrested? YES NO

Have you ever been physically abused? YES NO

Have you ever been sexually abused? YES NO

Have you ever been emotionally abused? YES NO

Have you ever been verbally abused? YES NO

Have you ever experienced or witnessed a traumatic event (accident, crime, major medical illness)? YES NO If YES, explain:
_____

Have you ever attempted suicide? YES NO

Do you currently have thoughts of suicide? YES NO If yes, do you have a suicide plan? YES NO

Do you have access to guns/weapons? YES NO

Are you thinking of hurting someone else now? YES NO

Have you ever hurt or thought of hurting someone else? YES NO

Substance	Please Circle	In the past	Recently (past 6 months)	Prefer to discuss
Tobacco	**YES NO**			
Alcohol	**YES NO**			
Illegal substances	**YES NO**			
Non-Prescribed Drug	**YES NO**			
Abused a prescribed drug	**YES NO**			