Walston Health Services

6165 Fuller Court, Suite 2 Alexandria, VA 22310
(703) 924-9810 Fax: (703) 924-7044 walstonhealthservices@gmail.com

Mental Health Intake Questionnaire

Please answer the following questions to the best of your ability. Your answers will help us to better understand what concerns you may be having now. This will also help us focus on specific issues and more effectively use your time with us.

Today's Date:___________

Name:____ SSN#:_____-_______-___
Last, First, M.I.

Age:____ Sex:____ Ethnicity/Nationality:___________________ DOB:______________________

Marital Status: ❑ Single ❑ Engaged ❑ Married ❑Divorced ❑Remarried ❑Widowed

Home Address:____
Street

____
City State Zip

Cell phone number:____________________________Home phone number:_______________________________

Who referred you to this clinic?____

What is your reason for being seen? ____

____

What are your expectations?____

____

____

____

Have you had any of these symptoms or experiences recently: If yes, length of time

Symptom	Yes	No	If yes, length of time
Depressed mood	❑ Yes	❑ No	______________
Big change in appetite or weight (up or down)	❑Yes	❑ No	______________
Changes in sleep patterns or quality of sleep	❑Yes	❑ No	______________
Constant feeling of fatigue, tiredness or low energy	❑Yes	❑ No	______________
Feeling of worthlessness or excessive guilt	❑Yes	❑ No	______________
Decreased ability to think or concentrate	❑Yes	❑ No	______________

Name: ____

Decreased interest in enjoyable activities	❑Yes	❑ No	_______________
Constant anxiety or excessive worry	❑Yes	❑ No	_______________
Avoidance of a specific object or situation	❑Yes	❑ No	_______________
Intense memories of any previous traumatic events	❑Yes	❑ No	_______________
Unusual experiences that cause distress	❑Yes	❑ No	_______________
Constantly on guard, watchful or easily startled	❑Yes	❑ No	_______________
Feelings of being numb or detached from others	❑Yes	❑ No	_______________
Unpredictable mood swings	❑Yes	❑ No	_______________
Thoughts of hurting yourself or someone else	❑Yes	❑ No	_______________
Changes in the use of alcohol or other substances	❑Yes	❑ No	_______________
Recent or past incidents of family violence (Domestic violence or child abuse)	❑ Yes	❑ No	_______________
Legal or disciplinary issues	❑Yes	❑ No	_______________

Mental Health History

Have you participated in any previous counseling or group therapy? If yes, please describe:________________________

____

____

Have you ever taken medication for mental health symptoms? If yes, please list the medications:___________________

____

____

Have you ever been hospitalized for mental health reasons? If yes, please describe:_______________________________

____

____

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Name:____

Is there any family history of mental health problems (nervous breakdown, suicide, substance abuse problems, ect)? If yes, please describe:____

____

____

Medical History

Do you have any current medical conditions? If yes, please list:____

____

____

List all allergies:____

____

Are you currently taking any medication (including herbal, supplements, and over the counter)? If yes, please lists:____

____

____

____

Do you have any current pain? If yes, please rate on a scale from 0 (no pain) to 10 (intense pain) and describe the location:
Pain level_______Location of pain:____

Substance Use History

How often do you have a drink containing alcohol?
- ❑ Never
- ❑ Monthly or less
- ❑ 2-4 times a week
- ❑ 2-3 times a week
- ❑ 4 or more times a week

How often during the past year have you needed a first drink in the morning to get yourself going after drinking the night before?
- ❑ Never
- ❑ Less than a month
- ❑ Monthly
- ❑ Weekly
- ❑ Daily or almost daily

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How many drinks containing alcohol do you have on a typical day when are drinking?
❑1-2
❑3-4
❑5-6
❑7-9
❑10 or more

How often do you have six or more beers or Drinks on one occasion?
❑Never
❑Less than monthly
❑Monthly
❑Weekly
❑Daily or almost daily

How often during the past year have you found that you were unable to stop drinking once you had started?
❑ Never
❑Less than a month
❑Monthly
❑Weekly
❑Daily or almost daily

How often during the past year have you failed to do what was normally expected of you, because of your drinking?
❑Never
❑Less than a month
❑Monthly
❑Weekly
❑Daily or almost daily

How often during the past year have you had a feeling of guilt or remorse after drinking?
❑Never
❑Less than monthly
❑Monthly
❑Weekly
❑Daily or almost daily

How often in the past year have you been unable to remember what happened the night before because you had been drinking?
❑Never
❑Less than monthly
❑Monthly
❑Weekly
❑Daily or almost daily

Have you or someone else been injured as a result of your drinking?
❑No
❑Yes, but not in the last year
❑Yes, during the past year

Has a friend, relative, doctor, or other health worker been concerned about your drinking or suggested you cut down?
❑No
❑Yes, not in this last year
❑Yes, during the last year

Have you ever used any illegal or illicit drugs? If yes, please list the drugs, frequency of use, and date of last use:______
____
____

Have you ever attended alcohol and/or drug treatment? If yes, please list the dates and type of treatment:____________
____
____

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Name: ____

What is your current caffeine/ energy drink/ supplement use? Please describe amount and types: _________________

____

Do you use tobacco? ❑YES ❑ NO How much?____

Personal History/ Background

I mainly grew up in the city of or rural area near?

My family's financial situation when I was growing up was? ❑Upper ❑Upper Middle ❑Middle ❑Lower Middle ❑ Lower income

I have_______ brothers and _______ sisters. I was born 1st, 2nd, 3rd, 4th, or other______

Father's job:____

How did you get along with your father?____

Mother's job: ____

How did you get along with your mother?____

My parents were? ❑Never Married ❑Married ❑Divorced ❑Widowed.

If divorced, how old were you?____

Did anyone else live with you? ❑Yes ❑No

Discipline in my family consisted of:____

As a child, I had: ❑No ❑Few ❑Many friends. Now I have ❑ No ❑Few ❑Many friends.

Number of school years you completed?____ Age when completed:_________

How were your grade in school? ❑Excellent ❑Good ❑Fair ❑Failing

Were you in any special classes? If yes, what types:____

With my teachers I got along: ❑Very Well ❑Okay ❑Did Not

With other students I got along: ❑Very Well ❑Okay ❑Did Not

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Name: ____

List school activities/ sports/ favorite subjects:____

____

Were you ever placed on probation, suspended, or expelled from school? If yes, please explain when, why and number of times:____

____

Did you ever have problems with law enforcement agencies prior to enlistment? If yes, please explain when and why:

What kind of jobs did you have prior to joining the military?___________________________________

____

Please place a check by any of the following that you may have experienced and not your age at the time:

Yes	Age		Yes	Age		Yes	Age	
❑	_____	Nail biting	❑	_____	Anger control	❑	_____	Physical abuse
❑	_____	Sleep Walking	❑	_____	Cruelty to animals	❑	_____	Verbal abuse
❑	_____	Bed Wetting	❑	_____	Stealing	❑	_____	Sexual abuse
❑	_____	Bad Nightmares/ Night terrors	❑	_____	Reckless driving	❑	_____	Running away
❑	_____	Hyperactivity	❑	_____	Fire setting	❑	_____	Over/Under eating

If married, how long?_____Spouse's age:_____Is this the first marriage for both? ❑Yes ❑No
If not, please describe:____

Length of dating before marriage?____

Do you have any children? ❑Yes ❑No If yes, how many?_____ What are their ages?____________Do they live with you? ❑Yes ❑No

How would you describe your strengths and weaknesses?____________________________________

____

____

Name: ____

Has religion, faith, or spiritual beliefs been an important part of your life in the past? ❑Yes ❑ No
Currently? ❑Yes ❑ No

If yes, please list your particular denomination or religious preference:_______________________________
____

Patient's Signature:____

Date:________________________

By signing this, you agree that you have read and understood all documents on these forms. You also agree that to the best of your knowledge, all personal answers and statements on these form are correct and true.