

**Directorate of 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 efficiently use your time with us.

Today's Date: _____

Name: _____ Sponsor's SSN#: _____
Last, First, M.I.

Age: _____ Sex: _____ Ethnicity/Nationality: _____ DOB: _____

Marital Status (Circle): Single, Engaged, Married, Divorced, Remarried, Widowed

Rank/Rate: _____ Branch: _____ Status _____ Years of Active Duty Service _____ years and _____ months

EAOS _____ Time at present command _____ years _____ months

Command: _____ Base location: _____ Division: _____

Quarterdeck/ CQ ph #: _____ Medical: POC: _____ ph#: _____

Personal Address (Local):

Street: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Home Phone: _____

Who referred you to this Clinic? _____

If you were directed by your command, do you object to being seen here or being seen by a Mental Health Professional?
(Please circle) YES NO

Did your command give you a letter ordering you to come to this evaluation?
YES NO

What is your reason for being seen? What are your expectations?

Have had any of these symptoms or experiences recently:		If Yes, length of time:
Depressed mood	Yes / No	
Big changes in appetite or weight (up or down)	Yes / No	
Changes in sleep patterns or quality of sleep	Yes / No	
Constant feelings of fatigue, tiredness or low energy	Yes / No	
Feelings of worthlessness or excessive guilt	Yes / No	
Decreased ability to think or concentrate	Yes / No	
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 (Civilian or Active Duty)	Yes/ No	

Deployment History:

Is this visit related to deployment in any way? Please describe: _____

How many times have you deployed?_____ When is your next deployment/underway?_____

Did you have any injury(ies) during your deployment from any of the following? (Check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> No injuries | <input type="checkbox"/> Fall |
| <input type="checkbox"/> Fragment <input type="checkbox"/> Bullet | <input type="checkbox"/> Blast (IED, RPG, Land mine, Grenade, etc) |
| <input type="checkbox"/> Vehicular (any time of vehicle, including airplane) | <input type="checkbox"/> Other: specify_____ |

If applicable, did any injury received while you were deployed result in any of the following? (Check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Being dazed, confused or seeing stars | <input type="checkbox"/> Losing consciousness for longer than 20 minutes |
| <input type="checkbox"/> Not remembering the injury | <input type="checkbox"/> Having any symptoms of concussion afterward (headache, dizziness, irritability, etc) |
| <input type="checkbox"/> Losing consciousness (knocked out) for less than a minute | <input type="checkbox"/> Head injury |
| <input type="checkbox"/> Losing consciousness for 1-20 minutes | <input type="checkbox"/> None of the above |

Are you currently experiencing any of the following problems that you think might be related to a possible head injury or concussion? (Check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Ringing in the ears |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Memory Problems | <input type="checkbox"/> Sleep problems |
| <input type="checkbox"/> Balance problems | <input type="checkbox"/> Other specify: _____ |

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: _____

Is there any family history of mental health problems (nervous breakdown, suicide, substance abuse problems, etc)? 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)? Is yes, please list: _____

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?

- 0 Never
- 1 Monthly or less
- 2 2-4 times a week
- 3 2-3 times a week
- 4 4 or more times a week

How many drinks containing alcohol do you have on a typical day when you are drinking?

- 0 1 or 2
- 1 3 or 4
- 2 5 or 6
- 3 7 to 9
- 4 10 or more

How often do you have six or more beers or drinks on one occasion?

- 0 Never
- 1 Less than monthly
- 2 Monthly
- 3 Weekly
- 4 Daily or almost daily

How often during the past year have you found that you were unable to stop drinking once you had started?

- 0 Never
- 1 Less than monthly
- 2 Monthly
- 3 Weekly
- 4 Daily or almost daily

How often during the past year have you failed to do what was normally expected from you, because of drinking?

- 0 Never
- 1 Less than monthly
- 2 Monthly
- 3 Weekly
- 4 Daily or almost daily

How often during the past year have you needed a first drink in the morning to get yourself going after drinking the night before?

- 0 Never
- 1 Less than monthly
- 2 Monthly
- 3 Weekly
- 4 Daily or almost daily

How often during the past year have you had a feeling of guilt or remorse after drinking?

- 0 Never
- 1 Less than monthly
- 2 Monthly
- 3 Weekly
- 4 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?

- 0 Never
- 1 Less than monthly
- 2 Monthly
- 3 Weekly
- 4 Daily or almost daily

Have you or someone else been injured as a result of your drinking?

- 0 No
- 2 Yes, but not in the last year
- 4 Yes, during the last year

Has a relative, friend, doctor, or other health worker been concerned about your drinking or suggested you cut down?

- 0 No
- 2 Yes, but not in the last year
- 4 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: _____

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 (circle) upper, upper middle, middle, lower middle, lower income level.

I have _____ brothers and _____ sisters. I was born 1st, 2nd, 3rd, 4th, 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? _____

Discipline consisted of _____ in my family.

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 grades in school? _____

Were you in any special classes? If so, what types _____

With my teachers I got along very well, got along okay, did not get along.

With other students I got along very well, got along okay, did not get along.

List school activities/sports/favorite subjects: _____

Were you ever placed on probation, suspended, 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 kinds 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 note your age at the time:

	Age		Age		Age
Nail Biting		Anger control problems		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?_____ If not, please describe:_____

Length of dating before marriage?_____ Do you have any children?_____ If yes, how many?_____

What are their ages?_____ Do your children live with you?_____

Have you every had any difficulties in the military that resulted in a hearing, mast, trial and/or courts martial?_____

If yes, please give details, charges and the outcome:_____

What awards/decoration have you received in the military or civilian life?_____

My evaluations have averaged:_____

If you are on Active Duty, has your attitude changed since your enlistment?_____ If yes, in what way?_____

Are you working within rate?_____

How would you describe your strengths and weaknesses?_____

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 documentation on these forms. You also agree that to the best of your knowledge, all personal answers and statements on these forms are correct and true.