



Name: \_\_\_\_\_

Family Member Prefix/SSN: \_\_\_\_\_

Date: \_\_\_\_\_

Have you or your sponsor been deployed to a combat zone?

Yes (self) \_\_\_ Yes (sponsor) \_\_\_ No \_\_\_

If so, where?

Iraq \_\_\_ Afghanistan \_\_\_ Other \_\_\_\_\_

If so, within the last:

3 months \_\_\_ 6 months \_\_\_ Year \_\_\_ Earlier \_\_\_

Do you believe that the problem for which you are being seen today is related to a deployment of any type?

Yes \_\_\_ No \_\_\_

If so, what sort of deployment?

Combat Zone \_\_\_ Ship \_\_\_ Ground deployment (non-combat) \_\_\_

Other \_\_\_\_\_

What specific problems do you believe are related to deployment?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Provider \_\_\_\_\_

Time \_\_\_\_\_

*Mental Health Services-Adult Outpatient Services*  
**NAVAL MEDICAL CENTER SAN DIEGO**  
**34800 Bob Wilson Drive, San Diego CA 92134**  
**(619) 532-5761**

Dear Service Member,

Our goal is to provide the highest quality of care possible. However, during this time of high operational tempo, the need for treatment in our clinic is often greater than we can support. We have a firm commitment to see all active duty staff referrals, without turning anyone away. However, many family members in need of treatment are turned away or placed on waiting lists. And our high rate of no-shows contributes to long wait times for both family members and active duty. Therefore, we have established the following NO-SHOW policy:

*Please initial in front of each item*

- \_\_\_\_\_ I. We require at least a **48-hour advance notice** if you are unable to keep a scheduled appointment. This allows us to offer any open appointments to other patients.
- \_\_\_\_\_ II. If you do not cancel your appointment **at least 48 hours in advance**, or if you do not present yourself for your scheduled appointment, you will be recorded as a no-show.
- \_\_\_\_\_ III. If you no-show for an appointment, we may call your **home and/or command** to ensure your safety.
- \_\_\_\_\_ IV. Your medical appointment should be considered your designated place of duty. If you no-show, you are considered UA. Active duty members may be held to a higher standard of accountability for missed appointments than their family members, especially if they are in a Limited Duty status or pending a medical board. A no-show may result in termination of Limited Duty status or an addendum to a medical board documenting non-compliance with treatment.
- \_\_\_\_\_ IV. Please arrive **15 minutes prior** to your appointment. This allows time for the check-in process and an assessment of vital signs if you are taking psychiatric medications. If you arrive later, you may lose your appointment to a standby patient, or your provider may have to devote less time to your treatment.
- \_\_\_\_\_ V. Please plan your visit to our clinic to allow time to park and still present for your appointment **15 minutes early.**

\_\_\_\_\_ VI. Two consecutive no-shows or three or more no-shows in a 6-month period may result in your **termination** from the clinic. If this happens, you will be referred back to your Primary Care Manager for further evaluation and treatment.

\_\_\_\_\_ VII. If you miss a scheduled group appointment, you will be marked as a **no-show** the same as you would be for an individual appointment.

\_\_\_\_\_ IX. I authorize AOP Mental Health staff to contact my **home** and/or **command** to assure my safety/accountability in the event that I no-show for an appointment.

Please provide the name and contact number of a work supervisor whom we may contact if you are a no-show. Be aware that if the individual listed is absent from work that day, we will be required to speak with the person covering for him/her.

Name: \_\_\_\_\_ Position: \_\_\_\_\_

Phone number: \_\_\_\_\_

**I HAVE READ AND UNDERSTAND THE MISSED APPOINTMENT POLICY OF THE NMCSO ADULT OUTPATIENT MENTAL HEALTH UNIT.**

If there are special circumstances that prevent you from making your appointment and need to be considered, please discuss these with your provider.

\_\_\_\_\_  
SIGNATURE OF PATIENT

\_\_\_\_\_  
DATE

\_\_\_\_\_  
REVIEWED BY (MHU Staff)

It is likely that you have been referred to our clinic to assist you with a problem or problems that you (or your provider) are concerned about.

Our team of psychiatrists, psychologists, social workers, nurses and corps staff is committed to understanding what has been troubling you and to help you improve your situation. Coming here is a good first step. The next step is to fill out some paperwork and to meet with a mental health professional to begin the process of understanding and healing.

Most mental health disorders or conditions can be best treated with a combination of what we can offer you and what you can do for yourself. What follows is an overview of how this healing process usually occurs.

### **What We Can Offer You**

An Assessment Interview: We will conduct an Initial Assessment Interview to gain an understanding of your concerns. We want to hear about your current symptoms, difficulties you have been facing, and ask questions about your past, your present circumstances, and your future goals.

Medication: Depending upon the problems you are having, our psychiatrist (M.D.) may recommend medication. Should this occur, we will fully discuss the type of medications available, their potential benefits, and the possible side effects you may experience. We will discuss with you how long it may be helpful to take the medications. If you do take medication, your doctor (either in Mental Health or your referring doctor) will meet with you on a regular basis to ensure that this medication is working for you and if necessary adjust the medication to best fit your needs.

Psychotherapy: If we agree that mental health services can help you with your problem, we will most likely offer psychotherapy. Psychotherapy is helpful for most mental health problems, either alone or in combination with medication. Psychotherapy will be offered by a psychiatrist (M.D.), Psychologist (Ph.D. or Psy.D.) or Licensed Clinical Social Worker (LCSW).

There are several types of psychotherapy including classes and/or workshops that teach skills needed to overcome your difficulties. Both research and our clinical experience show that psychotherapy is an important component of treatment for the majority of mental health disorders. You can increase the probability of improvement and preventing the problem from returning through your participation in psychotherapy.

## STEPS YOU CAN TAKE TO IMPROVE YOUR MENTAL HEALTH

In order for mental health treatment to be effective, it is essential that you participate fully in making every effort to improve your mental health. If you do not, the chances of improvement are far less. If you do make every effort, your chances for improvement will increase.

1. *If given medication, take it as prescribed.* If you have any questions, side effects, etc., please tell your doctor at your next regular visit, or call him/her immediately if it cannot wait.
2. *If psychotherapy is recommended, attend regularly.* Psychotherapy (including classes and/or workshops) is an essential part of improving most mental health problems. If psychotherapy is recommended, attending regularly gives you the best chance of improving your mental health. Many people have a very busy schedule, and find it challenging to make the time to attend weekly sessions. However, if you do, your mental health has a much better chance of improving. Sometimes difficult feelings or memories surface as a result of working through one's problems. This is a good sign that you are working hard to overcome your difficulties, and you should bring such reaction to the attention of your therapist.
3. *Lead a healthy lifestyle.* Regular exercise, healthy regular meals, regular sleep patterns, reducing intake of recreational substances (such as alcohol, caffeine, and tobacco) and regular social interactions are essential to improving your physical and mental health. Although these activities can be difficult when you are not feeling well, engaging in them on a regular basis will help you feel better.

Just like a patient with heart disease or diabetes has a better chance of improving his or her health with a combination of lifestyle change and appropriate use of medication, most mental health problems are best improved with a combination of what we can offer you and what you can do for yourself. We are here to help you find ways to help yourself, and to offer any additional support that we can.

Our policy is to offer up to 12 visits as warranted (this includes no-shows) and then evaluate progress to assess the need of future visits. If you are unable to come to your appointment we request that you call and notify your provider **at least 24 hours in advance**. If you are a family member or a retiree, you have the option of calling TRICARE Network and see a mental health provider in your neighborhood. Again, we are committed to doing our best to help you improve your situation. We want to make sure that you understand our commitment, and that your efforts are an essential part of your mental health.

Please sign below to show that you have read and understand the above.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**CONSENT FOR TREATMENT AND LIMITS OF  
CONFIDENTIALITY (PRIVACY)**

1. **QUESTIONNAIRE:** What follows is a personal history questionnaire. It covers a wide variety of concerns and provides the mental health staff with background information about you. Please attempt to answer all questions even if they do not seem relevant to you.
2. If you are an active duty member, according to SECNAVINST 6320.24A it is important to be aware that you have certain rights. An active duty member has a right to not see a Mental Health provider, unless the referral is considered to be urgent (potential harm to self, others or environment) or the member is formally referred via a written command directed evaluation. Even under a command directed evaluation, an active duty member has a right to contact a lawyer, notify the Inspector General, seek a second opinion at own cost and have a command directed letter presented in writing. If you feel that you are being coerced or forced to have a mental health evaluation, and if you do not desire to have an evaluation today, please discuss this with your provider before proceeding with an assessment. We encourage you to ask questions of our staff if further clarification is needed.
3. **ROUTINE USES:** This information will be used primarily for evaluation and treatment of mental problems. It may also be used for teaching or research; in these cases, personal information, such as your name, social security number, and address, will be excluded.
4. **DISCLOSURE:** Disclosure is voluntary. There are no legal consequences for refusing to disclose; however, this may limit our ability to help you.
5. **PROCEDURE:** Procedures may include face-to-face interview, audio/video taping of interview (with consent and prior knowledge), psychological testing, and other specialized procedures such as medication monitoring or referrals to other medical resources. A written summary of your care is kept in your medical record.
6. **LIMITATIONS:** Confidentiality (privacy) is the law and your right, but there are exceptions. It is important for you to know that there are limitations to confidentiality. This means that access to information in your medical record is allowed when required by law and/or regulations. Example of these limits are:
  - a. If you are on active duty, your Chain of Command may have access to information contained in your medical record if there is a need to know.
  - b. Your records may be subpoenaed when ordered by a judge.
  - c. If mental health staff determines that you are at significant risk of harm to yourself or someone else, then appropriate action will be taken to protect you and others.
  - d. In situation of suspected child, partner or elder abuse, appropriate action to report and protect will be taken.
  - e. If you tell us a violation of military regulations, military law or civilian law, we may be required to disclose this information to others.
  - f. Other health care staff at this facility may have access to information in your medical record without written consent.

Continued to the next page

7. **STATEMENT:** I have read the above. I freely and voluntarily agree to undergo a mental h  
evaluation at this time.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Provider Signature

\_\_\_\_\_  
Date

PERSONAL QUESTIONNAIRE

The purpose of this questionnaire is to obtain a comprehensive understanding of your background. By answering these questions as thoroughly and as accurately as you can, you will facilitate the evaluation and make better use of your actual time. PLEASE PRINT on lines or CIRCLE appropriate response. Thank you for your cooperation.

I. IDENTIFYING DATA

1. Last Name: \_\_\_\_\_ First name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

2. Family Member Prefix / Sponsor's SSN \_\_\_\_\_ / \_\_\_\_\_

3. Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

4. Marital Status: Single \_\_\_ Married \_\_\_ Separated \_\_\_ Divorced \_\_\_ Widowed \_\_\_

5. Ethnic Identity: Caucasian \_\_\_ African-American \_\_\_ Hispanic \_\_\_ Asian \_\_\_ Native American \_\_\_ Other (please specify) \_\_\_\_\_

6. Religious preference (optional): \_\_\_\_\_

7. Branch of Service: Navy \_\_\_ Marine Corps \_\_\_ Army \_\_\_ Air Force \_\_\_ Coast Guard \_\_\_

8. Rate/Rank: \_\_\_\_\_

9. Duty Status: Full Duty \_\_\_ Light Duty \_\_\_ Limited Duty \_\_\_ PEB Submitted \_\_\_

10. Total time in service (years/months): \_\_\_\_\_ Continuous \_\_\_ Broken \_\_\_

11. Current Duty Station: \_\_\_\_\_

12. Time at present Duty Station: \_\_\_\_\_

13. Rotation Date: \_\_\_\_\_

14. Division Officer: \_\_\_\_\_ XO \_\_\_\_\_ CO \_\_\_\_\_

15. Occupation/Rating: \_\_\_\_\_

16. Home Address: \_\_\_\_\_

17. Home Phone Number (w/area code): \_\_\_\_\_ Is it OK to leave a message? Yes \_\_\_ No \_\_\_

18. Work/Duty Address: \_\_\_\_\_

19. Work Phone (w/area code): \_\_\_\_\_ Extension (if any): \_\_\_\_\_

Staff Use Only:

## II. EMOTIONAL SYMPTOMS

1. Who referred you to us? \_\_\_\_\_
2. Did you want to come? Yes \_\_\_\_\_ Not really, but I don't mind \_\_\_\_\_ No \_\_\_\_\_
3. What is the reason you've come to us at this time? \_\_\_\_\_
4. Give a brief account of how the symptom(s) developed (onset to present) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
5. Current Major Stressors: Personal \_\_\_ Marital \_\_\_ Family \_\_\_ Financial \_\_\_ Occupational \_\_\_ Legal \_\_\_ Other \_\_\_
6. Have you experienced any of the following emotional symptoms over the past few months?

SYMPTOMS	No	Somewhat	Very much	If yes, how long has it been a problem for you?			
				Days	Weeks	Months	Years
a. feeling lonely/homesick	1	2	3	4	5	6	7
b. feeling angry, frustrated	1	2	3	4	5	6	7
c. difficulty sleeping	1	2	3	4	5	6	7
d. sleeping too much	1	2	3	4	5	6	7
e. recurrent nightmarc(s)	1	2	3	4	5	6	7
f. decreased appetite	1	2	3	4	5	6	7
g. eating when not hungry	1	2	3	4	5	6	7
h. difficulty concentrating	1	2	3	4	5	6	7
i. lack of motivation	1	2	3	4	5	6	7
j. frequent crying	1	2	3	4	5	6	7
k. feeling helpless/hopeless	1	2	3	4	5	6	7
l. feeling worthless	1	2	3	4	5	6	7
m. feeling guilty	1	2	3	4	5	6	7
n. feeling anxious, tense, panicky	1	2	3	4	5	6	7
o. fear of closed in spaces, heights, crowds, etc.	1	2	3	4	5	6	7
p. fear of losing mind, fear of dying	1	2	3	4	5	6	7
q. unusual experiences, like hearing voices or seeing visions	1	2	3	4	5	6	7

7. Have you sought help for the difficulties specified above? Yes \_\_\_ No \_\_\_  
 If yes, specify the help received: Counseling \_\_\_ Psychotherapy \_\_\_ Medication \_\_\_ Other \_\_\_
8. Have you ever had symptoms that resembled the present ones? Yes \_\_\_ No \_\_\_
9. If yes, did you seek help? Yes \_\_\_ No \_\_\_  
 If yes, specify the help received: Counseling \_\_\_ Psychotherapy \_\_\_ Medication \_\_\_ Other \_\_\_

Staff use only:

### III. SUICIDAL/HOMICIDAL THOUGHTS/BEHAVIOR

Please answer the following questions as completely and truthfully as possible.

1. How have you been feeling recently?	Very Good	Good	Fair	Poor
2. How well have you been functioning recently?	Very Good	Good	Fair	Poor
3. Have you been feeling depressed in the past month?		Very much ___	Somewhat ___	Not at all ___
4. Have you been feeling hopeless in the past month?		Very much ___	Somewhat ___	Not at all ___
5. Have you had suicidal thoughts in the past month?			Yes	No
6. Are you currently experiencing suicidal thoughts?			Yes	No
7. If Yes, do you have a plan?			Yes	No
8. Have you attempted to kill yourself in the past month?			Yes ___	No ___
8. a. If YES, please explain HOW and WHY you attempted to kill yourself:				
9. Prior to the past month, have you ever had suicidal thoughts?			Yes	No
10. Prior to the past month, have you tried to kill yourself?			Yes ___	No ___
10. a. If YES: How many times did you try to kill yourself? _____ Why did you try to kill yourself?  How did you try to kill yourself?  How old were you at the time?				
11. Have you had thoughts of killing someone else?			Yes ___	No ___
11. a. If YES: a. Whom? _____ b. Why? _____ c. How old were you at the time? _____				
12. Has anyone in your family ever attempted suicide?			Yes ___	No ___
12. a. If yes: a. Who? _____ b. How old were you at the time? _____				
13. Has anyone in your family ever committed suicide?			Yes ___	No ___
13. a. If yes: a. Who? _____ b. How old were you at the time? _____				
14. Has anyone close to you, besides family members, attempted suicide?			Yes ___	No ___
14. a. If yes: a. Who? _____ b. How old were you at the time? _____				
15. Has anyone close to you, besides family members, committed suicide?			Yes ___	No ___
15. a. If yes: a. Who? _____ b. How old were you at the time? _____				
Staff use only:				

IV. MEDICAL SYMPTOMS

1. Have you experienced any of the following medical symptoms during the past few months? (circle all that apply)

SYMPTOMS	If yes, how long has it been a problem for you?						
	No	Somewhat	Very Much	Days	Weeks	Months	Years
a. frequent headaches	1	2	3	4	5	6	7
b. dizziness, lightheadedness	1	2	3	4	5	6	7
c. fainting spells	1	2	3	4	5	6	7
e. convulsions, seizure, epilepsy	1	2	3	4	5	6	7
f. loss of consciousness	1	2	3	4	5	6	7
g. memory problem	1	2	3	4	5	6	7
h. racing heart beat, palpitation	1	2	3	4	5	6	7
i. chest pain, chest pressure	1	2	3	4	5	6	7
j. hand tremors, body shakes	1	2	3	4	5	6	7
k. numbness/tingling in hands	1	2	3	4	5	6	7
l. numbness/tingling in feet	1	2	3	4	5	6	7
m. difficulty breathing/shortness of breath	1	2	3	4	5	6	7
n. stomach problem, constipation	1	2	3	4	5	6	7
o. sexual problems, decreased sexual drive	1	2	3	4	5	6	7
p. chronically feeling tired, no energy	1	2	3	4	5	6	7
q. body aches	1	2	3	4	5	6	7
r. other (please specify):	1	2	3	4	5	6	7

2. Have you sought help for the above described symptoms? Yes \_\_\_ No \_\_\_  
 If yes, specify the help received: Counseling \_\_\_ Psychotherapy \_\_\_ Medication \_\_\_ Other \_\_\_
3. BEFORE now, have you had similar medical symptoms? Yes \_\_\_ No \_\_\_
4. Have you sought help for the above medical symptoms? Yes \_\_\_ No \_\_\_  
 If yes, specify the help received: Counseling \_\_\_ Psychotherapy \_\_\_ Medication \_\_\_ Other \_\_\_

Staff Use Only:

### V. BEHAVIORAL SYMPTOMS

1. Have you experienced any of the following behavioral symptoms over the past few months? (circle all that apply)

SYMPTOMS	If yes, how long has it been a problem for you?						
	No	Somewhat	Very Much	Days	Weeks	Months	Years
a. alcohol abuse, excessive drinking	1	2	3	4	5	6	7
b. drug abuse, drug experimentation	1	2	3	4	5	6	7
c. use of tobacco products	1	2	3	4	5	6	7
d. angry outburst, short temper	1	2	3	4	5	6	7
e. physical fights or other violence	1	2	3	4	5	6	7
f. conflict with authority	1	2	3	4	5	6	7
g. legal difficulties, arrest	1	2	3	4	5	6	7
h. XOJ, Captains Mast, Court Martial	1	2	3	4	5	6	7
i. speeding, reckless driving, DUI	1	2	3	4	5	6	7
j. excessive vomiting and forced vomiting	1	2	3	4	5	6	7
k. unreasonable feeling of being fat	1	2	3	4	5	6	7
l. extreme difficulty making friends	1	2	3	4	5	6	7
m. spending too much time on internet/video games	1	2	3	4	5	6	7
n. gambling	1	2	3	4	5	6	7
o. Other (specify)	1	2	3	4	5	6	7

2. Have you sought help for the above behavioral difficulties? Yes \_\_\_ No \_\_\_

If yes, specify the help received: Counseling \_\_\_ Psychotherapy \_\_\_ Medication \_\_\_ Other \_\_\_

3. BEFORE now, have you had similar behavioral symptoms? Yes \_\_\_ No \_\_\_

4. Have you sought help for the above behavioral symptoms? Yes \_\_\_ No \_\_\_

If yes, specify the help received: Counseling \_\_\_ Psychotherapy \_\_\_ Medication \_\_\_ Other \_\_\_

5. Were these problems related to alcohol/drugs? Yes \_\_\_ No \_\_\_

Staff Use Only:

VI. HISTORY OF SUBSTANCE USE

1. Have you ever used: a. Alcohol - Yes \_\_\_ No \_\_\_ b. Drug(s) - Yes \_\_\_ No \_\_\_

If you answered "No" to both questions, please proceed to the next section (Section VII)

If you answered "Yes" to one or both questions, please continue.

2. If you used drug(s), what kind of drug(s) did you use? \_\_\_\_\_

3. Age when you first used (please circle answer):

a. Alcohol:  Never  before 12  12-13  14-15  16-17  18-19  19-21  21 & Over

b. Drugs(s):  Never  before 12  12-13  14-15  16-17  18-19  19-21  21 & Over

4. How often do you use alcohol and/or drug(s)?

a. Alcohol:  Never  Once a Month  Once a Week  2-4x per week  5-6x per week  daily

b. Drugs(s):  Never  Once a Month  Once a Week  2-4x per week  5-6x per week  daily

5. Did you used to drink more or use drug(s) more than this?

6. How much do you usually drink per sitting? (Note: 1 drink = 12 oz beer; = 4 oz wine, = 1 oz hard liquor)

None 1-2 3-4 5-6 7-8 9-10 11-12 13-14 15-16 17 or more

7. Has alcohol or drug(s) caused any of these problems: (Check all that apply)

PROBLEMS	No	Once	More than once
a. medical problem(s) including loss of memory (blackout)	1	2	3
b. problem at work	1	2	3
c. problem with loved ones, including spouse, child abuse	1	2	3
d. financial problem	1	2	3
e. civilian legal difficulties	1	2	3
f. military disciplinary actions	1	2	3
g. other (specify)	1	2	3

8. Have you experienced the following after stopping alcohol or drug use? (Check all that apply)

PROBLEMS	No	Once	More than once
a. hangovers (headache, stomach upset)	1	2	3
b. shakes, tremor	1	2	3
c. sweats, perspiration	1	2	3
d. hallucinations: visual and/or auditory	1	2	3
e. seizures, convulsions	1	2	3

9. Have you ever received help for alcohol or drug abuse?

If yes, which one? DAPA \_\_\_ CAAC \_\_\_ NARD \_\_\_ AA \_\_\_ Antabuse \_\_\_ Other (specify) \_\_\_\_\_

10. Do you drink caffeinated beverages? Yes \_\_\_ No \_\_\_

If yes, what type? Coffee \_\_\_ Tea \_\_\_ Cola \_\_\_ Other \_\_\_\_\_ How much do you consume? \_\_\_\_\_

10. Do you use tobacco products? Yes \_\_\_ No \_\_\_

If yes, how much? \_\_\_\_\_ per \_\_\_\_\_ What brand? \_\_\_\_\_

VII. TREATMENT HISTORY

1. Describe any MAJOR illnesses, operations, accidents, head injuries, or other serious physical disturbances you have had:

	Age	Type	Complications
a. illness (es)			
b. operation(s)			
c. accident(s)			
d. loss of consciousness			
e. seizure(s)			
f. other (specify)			

2. Are you under treatment or evaluation for any medical problems? Yes \_\_\_ No \_\_\_

If yes, please specify for what and where you are receiving treatment: \_\_\_\_\_

3. Please list all medications, over the counter preparations, vitamins, birth control medication/devices, herbal remedies, and diet supplement(s) that you have recently been taking or are currently taking: \_\_\_\_\_

4. Please list any drug allergies that you have or reactions to medications that you have experienced: \_\_\_\_\_

5. Have you ever been evaluated/treated for psychological/psychiatric problem(s)? Yes \_\_\_ No \_\_\_

If yes, provide specifics (your age at the time, type of problem, length of treatment, etc.): \_\_\_\_\_

6. Have you ever been hospitalized for psychological/psychiatric problem(s)? Yes \_\_\_ No \_\_\_

If yes, provide specifics (your age at that time, reason for hospitalization, length of hospitalization, name of the hospital, diagnosis, etc.): \_\_\_\_\_

Staff use only:

VIII. FAMILY BACKGROUND

1. For the majority of your life before 18, where did you live? \_\_\_\_\_
2. Who were you raised by? \_\_\_\_\_
3. While you were growing up, how many times did your family move? \_\_\_\_\_
4. What is the ethnicity of your: Mother \_\_\_\_\_ Father \_\_\_\_\_ Spouse \_\_\_\_\_
5. Father's age: \_\_\_\_\_ (If deceased, your age when he died) \_\_\_\_\_ Occupation: \_\_\_\_\_
6. Briefly describe your father's personality: \_\_\_\_\_
7. How did you get along with your father while you were growing up? \_\_\_\_\_
8. How do you get along with him now? \_\_\_\_\_
9. Mother's age \_\_\_\_\_ (If deceased, your age when she died) \_\_\_\_\_ Occupation: \_\_\_\_\_
10. Briefly describe your mother's personality: \_\_\_\_\_
11. How did you get along with your mother while you were growing up? \_\_\_\_\_
12. How do you get along with her now? \_\_\_\_\_
13. Your parents were/are: Never married \_\_\_ Married \_\_\_ Separated \_\_\_ Divorced \_\_\_
14. How old were you when your parents: Separated \_\_\_ Divorced \_\_\_
15. Briefly describe your parents' marriage: \_\_\_\_\_
16. If you have a step-parent(s), briefly describe your relationship with him/her/them: \_\_\_\_\_
17. How many siblings do you have? Brothers \_\_\_ Sisters \_\_\_ Step-brothers \_\_\_ Step-sisters \_\_\_ Half-brothers \_\_\_ Half-sisters \_\_\_
18. Where do you fall in the birth order? \_\_\_\_\_
19. How did you get along with your siblings while you were growing up? \_\_\_\_\_
20. How do you get along with your siblings now? \_\_\_\_\_
21. Has anyone in your immediate family (mother, father, sibling or spouse) received psychiatric treatment or been admitted to a hospital for mental illness or alcohol/drug problem? Yes \_\_\_ No \_\_\_

If yes, specify who and what for (check relevant box):

Illness	None	One family member	More than one family member	Your age when it happened
a. depression				
b. anxiety disorder				
c. alcoholism				
d. drug abuse				
e. schizophrenia				
f. manic-depressive disorder				
g. post-traumatic stress disorder				
h. other (specify)				

Staff use only:

**IX. CHILDHOOD AND ADOLESCENCE**

1. How would you describe your childhood and adolescence? \_\_\_\_\_

2. How were you disciplined and/or punished? \_\_\_\_\_

3. During your childhood and adolescence, specify if you have experienced any of the following (check relevant box):

Symptoms:	Never	Occasionally	Frequently	Age(s) when it occurred
a. nail biting				
b. thumb sucking				
c. bed wetting				
d. sleep walking				
e. stammering/stuttering				
f. frequent nightmares				
g. hyperactivity				
h. fear of school				
i. other (specify)				

4. During your childhood and adolescence, specify if you had any of the following behavior problems (check relevant box):

Illness:	Never	Occasionally	Frequently	Age(s) when it occurred
a. temper tantrum				
b. frequent fights with peers				
c. vandalism				
d. fire setting, playing with matches				
e. shoplifting, stealing				
f. running away from home				
g. cruelty to animals				
h. arrested by police				
i. other (specify)				

5. Looking back, *during your childhood and adolescence* (before the age of 18) do you consider yourself to have been (check relevant box):

Type of Abuse:	Never	I'm not sure	Yes
a. physically abused			
b. emotionally abused (berated, belittled)			
c. emotionally neglected (deprived, left alone, unsupervised)			
d. sexually abused/molested			
e. were your parents violent toward each other?			

6. Have you received any professional help for childhood abuse?

If yes, provide details: \_\_\_\_\_

Staff use only:

X. EDUCATION

1. Age you started school: \_\_\_\_\_ Age you finished high school: \_\_\_\_\_
2. Please circle the highest level of education completed: 1...2...3...4...5...6...7...8...9...10...11...HS Diploma \_\_\_\_\_ GED \_\_\_\_\_
3. Grade point average (GPA out of 4.0): High School \_\_\_\_\_ College \_\_\_\_\_ Post Graduate \_\_\_\_\_
4. What was your: a. Best subject \_\_\_\_\_ b. Worst subject \_\_\_\_\_
5. Did you have any learning disability or attend special education classes? Yes \_\_\_\_\_ No \_\_\_\_\_
6. What grade, if any, did you have to repeat? \_\_\_\_\_
7. Did you skip any grades? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, what grade(s)? \_\_\_\_\_
8. How old were you when you stopped attending school? \_\_\_\_\_
9. Why did you stop? \_\_\_\_\_
10. As a student, what were your major extracurricular activities? \_\_\_\_\_  
\_\_\_\_\_
11. How did you get along with other students? \_\_\_\_\_
12. How did you get along with your teachers? \_\_\_\_\_
13. During school did any of the following occur? (Check relevant boxes):

Symptoms	Never	Occasionally	Frequently	Age(s) when it occurred
a. skipping classes				
b. angry outbursts				
c. verbal agreement				
d. physical fights				
e. smoking in school				
f. drinking alcohol				
g. using drugs				
h. suspension(s) from school				
i. expulsion(s) from school				
j. other behavioral problems				

13. If you were expelled from school, what was the reason? \_\_\_\_\_

Staff use only:

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## XI. RELATIONSHIP HISTORY

Please note that if you are not married, the following questions apply to your partner/significant other as well:

1. What is your marital status? Single  Married  Separated  Divorced  Widowed
2. How old were you when you began dating? \_\_\_\_\_
3. How many significant relationships, lasting at least 6 months, have you had? \_\_\_\_\_
4. a. Your age when you got married? \_\_\_\_\_ b. How long did you date your spouse before marriage? \_\_\_\_\_
5. a. How old is your spouse? \_\_\_\_\_ b. What is your spouse's level of education? \_\_\_\_\_
6. Number of previous marriages: a. Yours \_\_\_\_\_ b. Spouse's \_\_\_\_\_
7. If you were married before, please provide details of previous marriage(s): a. Age when married \_\_\_\_\_  
b. Duration of marriage \_\_\_\_\_ c. Reason(s) marriage(s) ended \_\_\_\_\_
8. How would you describe your current marriage? \_\_\_\_\_
9. How would you describe your spouse's personality? \_\_\_\_\_
10. Describe your spouse's alcohol and/or drug use (check relevant box):

Substance	Never	Occasionally	Frequently
a. Alcohol			
b. Drug(s) specify			

11. a. Has your spouse abused you? Yes  No  b. Have you abused your spouse? Yes  No

If the answer to any of the above questions is "Yes", please provide details \_\_\_\_\_

12. Have you ever requested professional help for marital difficulties? \_\_\_\_\_

13. Do you have any children? Yes  No  Do they live with you? Yes  No

First Name	Age	Gender	Full, Half, Step, Adopted	Please describe any behavioral problems this child may be experiencing

14. Have you or your spouse ever physically abused your child/ren? Yes  No

If yes, please provide details: \_\_\_\_\_

15. Have you or your spouse ever emotionally neglected your child/ren? Yes  No

If yes, please provide details: \_\_\_\_\_

16. Have you or your spouse ever been investigated for alleged child abuse or neglect? Yes  No

If yes, please provide details: \_\_\_\_\_

Staff use only:

XII. OCCUPATIONAL DATA

*For non-military only:*

1. What is your occupation? \_\_\_\_\_
2. Please list the most important jobs you've held: \_\_\_\_\_
3. If you've changed jobs, why did you do it? \_\_\_\_\_
4. How do you get along with your coworkers/supervisors? \_\_\_\_\_
5. Are you satisfied to with your current job? \_\_\_\_\_
6. What is your opinion of your spouse's military job? \_\_\_\_\_

*For military members only:*

1. Age when you joined the service? \_\_\_\_\_
2. Why did you join the service? \_\_\_\_\_
3. What is your current job in the military? \_\_\_\_\_
4. Are you satisfied with your current job? \_\_\_\_\_
5. What do you like about the service? \_\_\_\_\_
6. What do you dislike? \_\_\_\_\_
7. How do you get along with your coworkers? \_\_\_\_\_
8. How do you get along with your superiors? \_\_\_\_\_
9. Do you plan to stay in the military? \_\_\_\_\_
10. What is the average on your performance evaluation for your overall career? \_\_\_\_\_
11. a. What year did you take the ASVAB? \_\_\_\_\_ b. Your AFQT score, if you know it: \_\_\_\_\_
12. Please list military schools that you have attended: \_\_\_\_\_
13. Awards, medals, decorations: \_\_\_\_\_
14. Have you ever been in combat? Yes \_\_\_\_\_ No \_\_\_\_\_ If "Yes", please provide details: \_\_\_\_\_
15. Have you ever had NJP, Captain's Mast(s)? Yes \_\_\_\_\_ No \_\_\_\_\_  
If "Yes", provide details: \_\_\_\_\_
16. Have you ever had a Court Martial? Yes \_\_\_\_\_ No \_\_\_\_\_  
If "Yes", provide details: \_\_\_\_\_
17. If you are retired, when did you complete military service? \_\_\_\_\_
18. a. If you are retired, do you work? Yes \_\_\_\_\_ No \_\_\_\_\_ b. What is your occupation? \_\_\_\_\_

XIII. ADDITIONAL DATA

1. Briefly describe your personality: \_\_\_\_\_

2. List your interests and hobbies: \_\_\_\_\_

3. List your talents, strengths, and accomplishments: \_\_\_\_\_

4. Are religious beliefs an important part of your life? Yes \_\_\_\_\_ No \_\_\_\_\_

5. How do you cope with stress? \_\_\_\_\_

6. Please recount any information which you consider important but did not mention previously: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

7. How strongly do you want help with your problem? a. Not at all \_\_\_\_\_ b. Somewhat \_\_\_\_\_ c. Very much \_\_\_\_\_

8. How do you think we can best help you? \_\_\_\_\_

\_\_\_\_\_

9. For you to feel that treatment has been successful, what would change/be different than now? \_\_\_\_\_

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