BALANCED
MENTAL HEALTH OF ARIZONA

Health History

What are the problem(s) for which you are seeking help today?

Current Symptoms:

Please describe the symptoms that you are experiencing (examples might include things such as impaired sleep, anxiety, change in mood, etc.)

Over the past WEEK have you had problems with...

(0-not at all 1-mildly 2-moderately 3-markedly 4-Extremely)

Feeling low, hopeless, or depressed?

1 2 3 4

Obtaining pleasure from doing things or having little interest in doing things?

1 2 3 4

Anxiety, nervousness, or feeling on edge or jumpy?

1 2 3 4

Excessive worrying?

1 2 3 4

Falling or staying asleep?

1 2 3 4

Agitation, anger, or irritability?

1 2 3 4

Concentration, attention, or distractibility?

1 2 3 4

Feeling like people are plotting against you, trying to hurt you, or spying on you?

Yes No Maybe

Hearing or seeing things that other people don't?

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Yes No Maybe

Have you wished you were dead or wished you could go to sleep and not wake up?

Yes No Maybe

Have you made plans or taken steps toward suicide?

Yes No Maybe

Lifetime Mood Symptoms

If under the age of 18, skip to MEDICAL HISTORY section.

Have there been at least 6 different periods of time (at least 2 weeks) when you felt deeply depressed?

Yes No

Did you have problems with depression before the age of 18?

Yes No

Have you ever had to stop or change your antidepressant because it made you highly irritable or hyper?

Yes No

Have you ever had a period of time during which you were more talkative than normal with thoughts racing in your head? If YES, what was the longest it lasted for?

Yes No

Have you ever had a period of time during which you felt any of the following: unusually happy; unusually outgoing; or unusually energetic? If YES, what was the longest it lasted for?

Yes No

Have you ever had a period of time during which you needed much less sleep than usual? If YES, what was the longest it lasted for?

Yes No

Health History

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Medical History

Can we contact your primary care provider?

Yes No

Name of Primary Provider and Contact Information

Date of last Wellness Exam:

Do you have any allergies? Yes/No

If you have any allergies or adverse reactions to medication, foods, etc, please list them here:

Do you have any history of the following:

Heart Disease Yes No

High Blood Pressure Yes No

Diabetes Yes No

High Cholesterol Yes No

Thyroid Disorder Yes No

Seizures Yes No

Migraines Yes No

Other Problems (specify):

Please list any (non-psychiatric) medications you are taking:

Health History

Past Psychiatric History

Have you ever had Outpatient Treatment? Yes No

If yes, list the reason and dates treated and the specialist (psychiatry, counseling, IOP, PHP)

Have you ever had Inpatient Psychiatric Hospitalization? Yes No

If yes, list the reason and dates treated.

Family Psychiatric History

Please note the family member who has been diagnosed or treated for any of the following diagnosis.

Alcohol Use Disorder

Substance Use Disorder

Anxiety

Bipolar Disorder

Depression

Post-traumatic Stress

Schizophrenia

ADHD

Other (specify):

Current Psychiatric Medications

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If you have ever taken any psychiatric medications, please note medication and dosage, when started and stopped, indicate if the medication was effective or if you had any reactions to the medication. Please use additional sheet if needed.

Social History

Current Living Situation:

Relationship Status:

Do you have children?

How would you identify your sexual orientation/identity?

Have you ever experienced abuse?

Highest Educational Level Completed

Do you work outside the home?

What is your profession?

Describe any public support (unemployment, food stamps) or private resources (faith based, natural supports).

Have you served in the military?

Do you exercise regularly?

Do you require special assistance including language and/or communication capabilities?

Health History

Have you ever been arrested?

Do you have any pending legal problems? If yes, please explain

Do you belong to a religion or spiritual group?

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Substance Use

Smoking/Tobacco Use

How many times during the day do you use tobacco products?

Do drink alcohol?

If yes, how many times in a week, do you drink alcohol?

Do you think you may have a problem with alcohol or drug use?

Has anyone else thought you have a problem with drugs or alcohol?

If yes, who and when

Have you ever been treated for alcohol or drug abuse?

Have you used any street drugs in the past 3 months?

Have you ever misused prescription medications? (taken a higher dose, sold them, etc.)

Please note substances you have tried, how you took them, how often you took them, age of first use, and the date you last used them.