Behavioral Health History Form

Patient Name: _____ Date:_____D.O.B._____

Please circle "yes" or "no" for each question.

1. Would you like help for your emotional or relationship problems, or do people tell you that you could benefit from help for your emotional problems? …….. Yes No

2. Are you currently prescribed medication for anxiety, depression, hearing voices, or for any other emotional problem?..... Yes No

3. Do you hear voices no one else hears, or see objects or things which others do not see?..... Yes No

4. Are you experiencing depression for weeks at a time, losing interest in most activities, and having trouble completing everyday tasks? …… Yes No

5. Do you give in to aggressive urges or impulses that result in serious harm to yourself, others or lead to the destruction of property?..... Yes No

6. Are you currently cutting yourself, participating in self-destructive behaviors or having thoughts of killing yourself?..... Yes No

7. Do you have periods of time when you are so full of energy and your ideas come very rapidly, when you talk nearly nonstop, when you move quickly from one activity to another, when you need little sleep, and when you believe you could do almost anything?..... Yes No

8. Do you worry excessively or feel anxious about several things every day? …… Yes No

9. In the past month, did you do something repeatedly without being able to resist doing it? Examples: Washing, counting, checking things, arranging things a certain way? ..... Yes No

10. Have you experienced or witnessed an extremely traumatic event that included actual or threatened death or serious injury that now haunts you?..... Yes No

11. Do you believe that people are spying on you, or that someone is plotting against you, or trying to hurt you?..... Yes No

12. Do you believe someone is reading your mind or can hear your thoughts, or that you can actually read someone's mind or hear what another person is thinking?..... Yes No

14. Are you concerned that maybe you are drinking too much alcohol or using any substances to excess?..... Yes No

15. Has someone else expressed concern about your alcohol/substance use?..... Yes No

16. Have you been under the care of a psychiatrist within the past six months?..... Yes No

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