Patient Health Questionnaire

(Please complete to the extent you feel able)

Name:_____

1) What significant life changes or stressful events have you experienced recently? _____

2) Have you previously received any type of mental health services (psychotherapy, psychiatric services, medications, counseling, etc)? _____

Previous therapist/practitioner: _____

3) Current Medications (if any): _____

4) How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very Good

5) How would you rate your current level of physical comfort/being free of pain?

Poor Unsatisfactory Satisfactory Good Very Good

6) Describe any physical problems you are having? _____

7) How would you rate your current sleeping habits?

Poor Unsatisfactory Satisfactory Good Very Good

8) What time do you usually go to sleep? Wake up? Do you nap? _____

9) How would you rate your level of satisfaction at work?

Poor Unsatisfactory Satisfactory Good Very Good

10) Is there anything stressful about your current work? _____

11) How would you rate your current mental/emotional health?

Poor Unsatisfactory Satisfactory Good Very Good

12) Do you feel depressed, sad, anxious, worried, etc? Please explain. _____

13) How many days per week do you drink alcohol? _____

14) Do you use other drugs? _____

15) Have you thought, or has anyone ever told you, you might have a problem abusing substances? _____

16) How would you rate your current level of physical activity?

Poor Unsatisfactory Satisfactory Good Very Good

17) How many days per week do you exercise? What type of activities do you prefer? _____

_____

18) If you are currently in a romantic relationship, how would you rate your current level of satisfaction?

Poor Unsatisfactory Satisfactory Good Very Good

19) If you are currently in a romantic relationship, how would you describe it? _____

_____

20) How would you rate your appetite or eating habits?

Poor Unsatisfactory Satisfactory Good Very Good

21) What do you consider to be some of your strengths? _____

_____

22) What do you consider to be some of your challenges? _____

_____

23) What would you like to accomplish during your time in therapy? _____

_____

_____

FAMILY MENTAL HEALTH HISTORY

1) Is there a family history of any of the following:

___Alcohol/Substance Abuse
___Anxiety
___Depression
___Bipolar Illness
___Domestic Violence
___Eating Disorder
___Physical/Sexual Abuse
___Obesity
___Obsessive Compulsive Disorder
___Personality Disorder
___Psychiatric Hospitalization
___Schizophrenia
___Suicide or Attempts
___Other (specify): _____

If yes, please specify the relationship (e.g., paternal grandfather, maternal aunt, sister, etc)_____

_____

_____

_____

2) How would you describe the relationship you currently have with your family (parents, siblings, etc)?_____

_____

_____

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