



Western Wisconsin Health
MENTAL HEALTH MEDICAL QUESTIONNAIRE - ADULT

Name: Birthdate: Today's Date:
Primary Care Physician: Medical Clinic:
Address: City: State/Zip:

- 1. May we contact your physician? Yes No
2. When was the last time you saw your physician? (date):
3. For what medical problems did you see your physician?:
4. What medical problems, if any, are you currently having?
5. Are those problems being treated?: By Whom?:
6. What medications are you currently using? Please include over-the-counter medications as well as herbal supplements:
7. List any medical problems that have been treated in the past.:
8. Is there a family history of medical problems?:
9. Is there a history of mental illness in your family? Please describe
10. Have you had any previous mental health treatment?: If so, please list with whom, date(s) of treatment, for what problems, medications used with dosages and outcome of the treatment.:
11. Please list any hospitalizations, serious illnesses, or operations, including dates and where treated.:
12. Do you have any hearing or sight loss, speech impairment, learning disability or other perceptual deficit/impairment?
13. Do you use alcohol or drugs? Type Used: How Long? Weekly Amount?:
14. Have you had any treatment for alcohol or drug problems?: When?: Where?: Outcome of treatment:



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15. Is there any family history of drugs or alcohol?:

16. Is there anything else in your medical history that would be helpful for us to know?:

RELATIONSHIPS: (Please place an (x) on any items that apply to your self.)

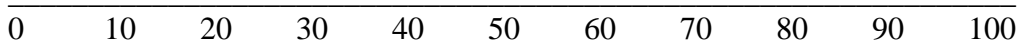
- Too few friends, Regularly talks / play with friends, Is overly shy, Makes friends easily, Others seem to be picking on my child, Plays mostly with younger children, Has enough friends, Often gets into fights with friends, Withdrawing from friends, Finds it hard to keep friends, Bullying or mean to friends, Hangs out with a "bad" crowd

SOURCE OF STRESS: (Please list the things/events/problems that are creating stress for yourself at the present time.)

- 1. 2. 3. 4. 5. 6.

CURRENT FUNCTIONING

Place and (x) on the following scale to indicate how well you are coping with things at the present time. 100% mean you are coping the best you ever have.



WHAT ARE YOUR GOALS IN COUNSELING

Please list the goals that you hope you will achieve in counseling. (Be as specific as you can.)

- 1. 2. 3.

HOW MANY SESSIONS DO YOU THINK YOU WILL NEED?

Please place and (x) in the answer which best describes our expectations.

- 1 - 3 sessions, 4 - 6 sessions, 7 - 9 sessions, 10 - 12 sessions, Other (please specify how many sessions)

Form Completed By (Signature) Date