

MENTAL HEALTH HISTORY:

Do any of the following apply to you? (Indicate Yes by using a check mark).

<input type="checkbox"/> Tension, Anxiety, Nervousness	<input type="checkbox"/> Depression
<input type="checkbox"/> Eating Disorder (binging, starving)	<input type="checkbox"/> Fears, Phobias
<input type="checkbox"/> Sexual Abuse/Assault	<input type="checkbox"/> Sexuality Concerns
<input type="checkbox"/> Physical/Emotional/Mental Abuse	<input type="checkbox"/> Anger/Aggression Problems
<input type="checkbox"/> Low Self-Esteem	<input type="checkbox"/> Difficulty Expressing Emotions
<input type="checkbox"/> Grief Issues	<input type="checkbox"/> Sleeping Disorders
<input type="checkbox"/> Suicidal Thoughts	<input type="checkbox"/> Self Harm Behavior
Have you ever been hospitalized for suicidal thoughts and/or suicidal attempts? If so when?	
Have you had suicidal thoughts in the past: <input type="checkbox"/> Two Weeks <input type="checkbox"/> Three Months <input type="checkbox"/> Six Months	
Have you ever had counseling for any of the above concerns? Give name below.	
Name:	Agency:
Date:	How Long:
Please indicate briefly what issues were addressed:	
Would you be willing to sign a release of information for N.A.C.M. to access reports from the above agency(s)? If not, why?	
Is counseling/therapy ongoing?	
What is your view of life at this present time?	