Name: _____

Case #: _____

Leigh Anne Mehldau, LCSW
Licensed Therapist/Certified Divorce Mediator

Patient Health and Symptom Questionnaire

In order to provide you with high quality and effective therapeutic services please review the following list of symptoms or health-related issues. Please check all symptoms that apply to how you are feeling at the present time:

☐ **Low/Bad Mood**	☐ **Feel Euphoric**	☐ **Bouts of Anxiety**	☐ **Need Orderliness**	☐ **Daily sleep attack**	☐ **Exercise a lot**	☐ **Foggy Thinking**
☐ **Low/No Interests**	☐ **Racing Thoughts**	☐ **Rapid Heart Rate**	☐ **Daily Rituals**	☐ **Need Daily Naps**	☐ **Body / Weight Issue**	☐ **Memory Changes**
☐ **Poor Sleep**	☐ **Lots of Energy**	☐ **Chest Tightness**	☐ **Cycling Thoughts**	☐ **Sleepy All Day**	☐ **Menses Changed**	☐ **Seizures**
☐ **Low/No Energy**	☐ **No need to sleep**	☐ **Short of Breath**	☐ **Abhor Germ / Dirt**	☐ **Sluggish Thinking**	☐ **Food Binging**	☐ **Migraines**
☐ **Hopelessness**	☐ **Rapid Talking**	☐ **Tremors/Tremble**	☐ **Check & Recheck**	☐ **My Hearing is Off**	☐ **Periodic Purging**	☐ **Tics / Twitches**
☐ **Can't Concentrate**	☐ **Spending Sprees**	☐ **Feeling of Doom**	☐ **Wash & Rewash**	☐ **Noises in My Ears**	☐ **Use Laxatives**	☐ **Fainting Spells**
☐ **Restlessness**	☐ **High/Low Moods**	☐ **Can't Leave Home**	☐ **On Constant Alert**	☐ **My Vision is Off**	☐ **Use Diet Aids**	☐ **Painful Menses**
☐ **Irritability**	☐ **Scatter Thoughts**	☐ **Excessive Worries**	☐ **Flashbacks**	☐ **I See Spots/ Things**	☐ **Very Impulsive**	☐ **Chronic Pain**
☐ **Appetite Changes**	☐ **Can't sit still**	☐ **Fidget or Pace**	☐ **Nightmares**	☐ **People Worry Me**	☐ **Explosive Temper**	☐ **Sexual Issues**
☐ **Low Self Esteem**	☐ **Can't stay on task**	☐ **Always on Edge**	☐ **I'm Very Shy**	☐ **Don't Trust People**	☐ **Feel Homicidal**	**OTHER:**
☐ **Suicidal Thoughts**	☐ **Very Distractible**	☐ **Mind Goes Blank**	☐ **Avoid Socializing and / or**	☐ **Feel Targeted**	☐ **Gambling Often**	☐ _____
☐ **Tearfulness**	☐ **Easily Board**	☐ **Muscle Tension**	☐ **Public Speaking**	☐ **Feel Surreal**	☐ **Hair Plucking**	☐ _____

How long have you been experiencing these symptoms? _____

What was most effective in managing these symptoms in the past? _____
_____

Of those listed above, which trouble you the most and you would like to actively address in therapy?
_____
_____

Medical Conditions: Current: _____ Past: _____

____ Asthma ____Thyroid Condition ____ Diabetes _____ Menopause ____ Traumatic Head Injury / Unconsciousness

____ Cancer ____ Migraine Headaches ____ Chronic Pain ____Neurological Condition _____ Other

If you answered “yes” or “other” to any of the conditions above, please explain:
_____
_____
_____

Use of Recreational Substances (including alcohol): Current _____ Past _____ Never _____

Drug(s) of Choice: _____

Do you consume alcohol? YES NO

_____ Daily
_____ Weekly/Weekends
_____ Socially
_____ Rarely
_____In the Past

When did you stop drinking and why? _____
_____

Do you currently, or have a history of intense anger, violent rages, or blackouts while intoxicated, or “high”?
Yes ____ No ____ Were you ever arrested and when?_____
_____

Were you ever arrested for driving under the influence of drugs or alcohol (DUI)? YES ____ NO ____

When and what was the result of your arrest? _____
_____

How long have you been “sober” or “clean”? _____

How many past attempts to stop drinking or using drugs?_____

When was the last time you tried to stop drinking or using drugs?_____

Past alcohol/substance abuse treatment? YES _____ NO _____
Dates: _____
Program/Hospital: _____
_____

Are you currently attending AA, NA, or are other family members attending meetings? YES ____ NO ____
How many meetings are you attending per week? _____

Have you been mandated by court to seek therapy services at this time? YES ____ NO ____

If YES, please explain: _____
_____

What is your personal goal for therapy with regard to your alcohol and/or substance use?

_____

_____

Your honesty regarding current or past alcohol or drug use is appreciated. Please be advised that at the time of the intake assessment or during the course of therapy, additional or alternative community-based services or treatment may be recommended. I will assist you with seeking other services and making referrals, as appropriate or necessary. Thank you.