Mental Health Screening Questionnaire

Contact Details

Patient First Name	Patient Last Name

Preferred Name	Patient Gender

Patient Maiden Name

Date of Birth	Medicare Number	Medicare reference No.	Medicare Expiry

Address

Relationship Status	Mobile No.	Home Phone No.	Work Phone

Email Address	Occupation

Emergency Contact

Contact Name	Contact no.	Relationship

Health Fund

Health Fund Name

Fund No.	Reference No.	Expiry Date

Name on the Card

Concession

Healthcare No.	Expiry Date

Pensioner Concession No	Expiry Date

Education History

How many years of formal schooling have you completed? (Circle no. of years) 6 7 8 9 10 11 12

Have you obtained any of the following educational qualifications or equivalent? (Please underline)

Junior/Achievement Certificate Leaving certificate/Matriculation/TEE Technical or Trade Certificate

Tertiary qualifications (what?)_____ Other: _____

Occupation: employed ❑ unemployed ❑ Centrelink benefit: _____

Occupation (current): _____

Occupation (past): _____

Occupational history

Can you please list all you jobs since finishing school. That includes volunteer work.

PERIOD EMPLOYED	EMPLOYER	POSITION HELD	REASON FOR LEAVING

Description of Presenting Problem

- Please state in your own words the nature of your main complaints, symptoms, and problems.

- On the scale below, please estimate the current severity of your problem(s)

No Problem 0	Mildly Upsetting 1	Moderately Upsetting 2	Highly Upsetting 3	Severely Upsetting 4	Extremely Incapacitating 5

History of Eating Problems: Please think about when your eating problems first started

Behaviours	Age when started	What else was going on at that time?
Worrying about my weight		
Dissatisfied with my body		
Restricting food intake (dieting)		
Binge eating		
Vomiting to control my weight		
Using laxatives to control my weight		
Using diuretics (water pills) to control my weight		
Exercising excessively to control my weight		
Menstruation (having my first period)		

What was your body like in childhood? (Please circle one): underweight/slight/average/chubby/overweight/obese

What is your current weight? _____Kg Height? _____

How long have you been at this weight ? _____years _____months

What has been your lowest weight? _____kg Age at lowest _____

What has been your highest weight? _____kg Age at highest _____

What weight would you like to be?_____kg

Psychiatric History: Have you ever suffered from any of the following problems?

Name and Disorder	Yes	Age at Diagnosis
Depression		
Schizophrenia		

Bipolar Disorder (Manic Depression)		
Bulimia Nervosa		
Anorexia Nervosa		
Binge Eating disorder		
Agoraphobia		
Panic Disorder		
Social Anxiety / Phobia		
Phobia/s - other		
Obsessive Compulsive Disorder		
Chronic Worry		
Epilepsy		
Alcoholism		
Drug Dependence (specify)		
Domestic Violence		
Sexual Abuse		

Have you been **in the past or currently** involved with any of the following?

	Yes	Year	Age	Reason
An outpatient mental health clinic				
Psychologist				
Psychiatrist				
Counsellor / therapist				
Group programme				

Have you **ever** been hospitalised for psychiatric/psychological problems? Yes / No

If yes, age at first admission: _____

Would you please provide us with further information about your times in hospital:

Approximate Year & Month	Which Hospital?	Length of Stay	Name of Disorder	Good outcome? Yes/No

Have you ever been hospitalised involuntarily? Yes / No If yes, when? _____

Have you had any previous episodes of attempted suicide or self harm (e.g., cutting, overdose)?

Description	How many times	Age of each occurrence

Medical History: Please list major illnesses and injuries you have suffered:

Type of medical illness/injury/surgery **Age**

_____

Medications/remedies	Name	Dose	Dates taken	Was it helpful?
Psychiatric medications prescribed <u>in the past</u>	1. 2. 3.	1. 2. 3.	1. 2. 3.	1. 2. 3.
<u>Current</u> a) Prescribed medications b) Over the counter herbal treatments/remedies (e.g., senna, ex-lax, ephedrine, St. John's Wort)	1. 2. 3. 1. 2. 3.	1. 2. 3. 1. 2. 3.	1. 2. 3. 1. 2. 3.	1. 2. 3. 1. 2. 3.

Substance Use **(parents reporting on child / adolescent symptoms may skip this section)**

Do you currently drink alcohol? Yes/No If yes, please complete the following questions:

At what age did you begin drinking alcohol?_____

How much alcohol do you currently consume? Please give details in relation to the standard drinks shown below:

Usual beverage (place a tick against the beverages you typically consume)	Current weekly amount (How many standard drinks do you consume in a typical week?)	How often do you consume this beverage in a typical week (e.g., daily)?
☐  A middy of regular beer (285ml)		
☐  A small glass of wine (120ml)		
☐  A nip of spirits (30ml)		
Other (please specify):_____		

If you no longer drink alcohol, when did you stop? _____

On average, how much did you drink in the past? _____

Do you currently smoke cigarettes? Yes /No How many each day? _____

If you no longer smoke cigarettes, when did you stop? _____

Do you use any of the following drugs? Please provide information where appropriate:

Type of drug	Age first used	How <u>much</u> of this drug do you use in a typical week?	How <u>often</u> do you use this drug in a typical week (e.g., daily)?
Marijuana ("dope", "pot")			
Amphetamines ("speed", "ice")			
Heroin			

Ecstasy			
Cocaine (“rock”, “crack”)			
Sedatives (“downers”)			

Personal and Social History:

Mother Living?_____If alive, give mother’s present age: _____

Occupation (past/present) _____

Deceased? _____If deceased, when did she die?_____

Relationship: satisfactory / unsatisfactory

Father Living?_____If alive, give father’s present age: _____

Occupation (past/present) _____

Deceased? _____If deceased, when did he die?_____

Relationship: satisfactory / unsatisfactory

Are your parents still together? Yes/No If no, how old were you when they separated? _____years

Sister/s name	**Age**	**Occupation**

Brother/s name	**Age**	**Occupation**

Child/s name	**Age**	**Sex**	**Where lives?**	**Occupation**

Family History of Psychiatric Problems

Has any member of your family, or a close relative, ever suffered from any of the following?

Psychiatric Problem	Mother	Father	Siblings (specify sis/bro)	Other relatives (specify e.g. maternal aunt, grandmother)
Eating disorder				
Depression				
Anxiety				
Schizophrenia				
Bipolar Disorder (manic depression)				
Epilepsy				

Alcoholism				

Past psychiatric history
Have you had any psychological or psychiatric illness previously? Have you ever seen psychiatrist, psychologist or counsellor? Please provide details.

Past medical history
Have you had any physical illness previously? Please include illnesses of the heart, lungs, liver, kidney, bone and thyroid. Please include illnesses such diabetes and cancers. Please include any operations or head injuries

Past family medical history
Have there been any psychological, psychiatric or physical illnesses in your family? Has anyone in your family committed suicide? Please include illnesses as above.

If anyone in your immediate family died please complete the following

Name	Relationship	Age at death	Cause of death

Marital status	
Names and ages of your children	

Previously, have you ever had (please circle):

1. Workcover or other compensation case/s	Yes	No
2. Legal or litigation cases	Yes	No
3.Bankruptcy	Yes	No