Jetson Counseling
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Self-Assessed Mental Health Assessment

I. Identifying Information: **Voluntary: _____** **Involuntary: _____**

Name: _____ Date of Birth: _____ Sex: _____ Age: _____

Attending Physician: _____ Phone: _____

II. Initial Complaint:

_____

_____

_____

_____

III. Your Goals with Counseling: (Ex.: Address Emotional, Psychological, Family, Relationship, Social, Environment, Physical & Spiritual)

1. _____
2. _____
3. _____
4. _____
5. _____

1.Family Circumstances: (Relationship to nuclear family, identify stressors and/or emotional cutoffs, disengagement, or enmeshments)

A. Family Relationships:

1.Relationship with mother:_____

_____

2.Relationship with father_____

_____

3.Relationship with siblings_____

_____

4.Relationship with spouse/significant other:_____

_____

5.Bereavement issues_____

_____

6.Important historical events_____

_____

7.Relationship with other care givers_____

_____

B.Current Living Arrangements: (Ex.: Nuclear, Adoptive, Blended, Residential Family)

_____

_____

_____

C. Childhood History: (Previous Living Arrangements Ex.: Nuclear, Adoptive, Blended, Residential Family Foster Care, Etc.)

_____

_____

_____

D. History of Trauma (Ex.: Physical, Emotional, Sexual, Spiritual, Ritual, Abandonment, Disability)

_____

_____

_____

E. Legal History/Status:

1._____

2._____

3._____

Vi. Social History:

A. Highest grade completed _____

B. Employed: Yes ____ No ____ Occupation _____

C. Previous Employment _____

D. Financial Stressors/Status: _____

F. Religious Affiliation/Issues/Bereavement/ Cultural and/or Ethnic Concerns: _____

_____

G. Peer Group Orientation and Environmental Issues: _____

_____

2.Medical History:

Currently Medical Problems:

Seizures	Diabetes	Thyroid Problems	Heart Problems
High Blood Pressure	Arthritis	Lung Problems	Cancer
Stomach Ulcers	Liver Problems	Kidney Problems	Stomach Pain
Nervousness	Forgetfulness	Depression	Numbness
Dizziness	Headache	Chest pain	Excessive Hunger
Muscle Tension	Feeling Restless	Feeling Keyed Up	
Feeling On Edge	Undiagnosed Pain	Irritable Bowel Syndrome	Other

Broken Bones: _____ Age: _____ Cause: _____

Broken Bones: _____ Age: _____ Cause: _____

My Health Is: ____ Excellent _____ Good _____ Fair _____Poor

Comments: _____

_____

Allergies – Medications, Food, Others: (Describe the reaction):

Comments: _____

_____

Head Trauma – Concussions/Loss of Consciousness (circle one)

Date_____Permanent Problems_____

Date_____Permanent Problems_____

Drug / Alcohol Use:

Tobacco: Never Used	Last Use	_____	Current Use	_____	Packs/Day Since _____
Alcohol: Never Used	Last Use	_____	Current Use	_____	Drinks/Use_____
Blackouts	How often do you Drink:			_____	
Marijuana	Last Use	_____	Current Use	_____	Frequency _____
Amphetamines	Last Use	_____	Current Use	_____	Frequency _____
Cocaine	Last Use	_____	Current Use	_____	Frequency _____
LSD	Last Use	_____	Current Use	_____	Frequency _____
Oxycotin	Last Use	_____	Current Use	_____	Frequency _____
Hallucinagins	Last Use	_____	Current Use	_____	Frequency _____
Heroin & Other Opiates	Last Use	_____	Current Use	_____	Frequency _____
Nicotine & Caffeine	Last Use	_____	Current Use	_____	Frequency _____
Psychedelics	Last Use	_____	Current Use	_____	Frequency _____
Steroids	Last Use	_____	Current Use	_____	Frequency _____
Over the counter	Last Use	_____	Current Use	_____	Frequency _____

Relationship Problems _____

Legal Problems _____

Work / School Problems _____

Comments: _____

_____

Women Only – OB/GYN:

Number of Pregnancies _____ Number of Births _____ Number of Abortions _____
Number of Miscarriages _____
Mood Problems Related To:
Menstrual cycle Pregnancies Menarche (initial menstrual period) Contraception use

3.Medications:

E. Current Medications
1._____
2._____
3._____
4._____
5._____

F. Past Medications and response
1._____
2._____
3._____
4._____

4.Psychiatric History:

A. Hospitalizations:
Date: _____ Location: _____ Reason: _____
Treatment: _____
Date: _____ Location: _____ Reason: _____
Treatment: _____
Date: _____ Location: _____ Reason: _____
Treatment: _____

B. Outpatient Treatment/Counseling
Date: _____ Location: _____ Reason: _____
Treatment: _____
Date: _____ Location: _____ Reason: _____
Treatment: _____
Date: _____ Location: _____ Reason: _____
Treatment: _____

C. Other Residential Placements:
Date: _____ Location: _____ Reason: _____
Treatment: _____
Date: _____ Location: _____ Reason: _____
Treatment: _____
Date: _____ Location: _____ Reason: _____
Treatment: _____

D. Family Psychiatric History (First Degree Relatives):
_____
_____
_____
_____

General Behavior

Normal For Culture	Eccentric	Irritable	Angry
Sensitive	Hostile	Outbursts	Impulsive
Silly	Passive	Unresponsive To Redirection	Friendly
Sarcasm	Isolates	Swearing	Yelling
Self-Mutilation	Apathetic	Passive/Aggressive	Demanding
Manipulative	Negative	Slowed Body Movements	Withdrawn
Hyperactive	Verbally Aggressive	Physically Aggressive	Overly Dramatic
Naïve	Uncooperative	Peculiar Posturing	Evasive
Somatic Complaints	Calm	Guarded	Tics
Tremors	Repetitive Acts	Aggressive	Poor Insight
Poor Judgment	Oppositional	Defiant	Memory Problems
Paranoia		Oppositional	Other

Comments: _____

Motor Activity

Normal For Culture	Active	Slowed	Decreased Energy
Hyper-Active	Fidgets	Impulsivity	Other

Comments: _____

5.Speech:

Speech

Normal for Culture	Decreased	Slowed	Soft
Slurred	Increased	Pressured	Loud
Mute	Broken	Stuttering	Other

Comments: _____

6.Emotions:

Stated Mood

Normal for Culture	Euphoric	Depressed	Irritable
Frightened	Unsteady	Anxiousness	Expansive
Despairing	Perplexed	Angry	Elevated
Hopelessness	Helplessness	Mood Swings	Other
No Energy	Low Self-esteem	Difficulty Making Decisions	Panic Attacks
Bright	Cheery	Euthymic (Normal Mood)	
Decreased Energy	Decreased Mood	Paranoia	Elevated Mood
Grief	Guilt	Shame	Worthless
Tearful	Obsessive	Compulsive	
Recurrent & Persistent Thoughts That Cause Anxiety		Recurrent & Persistent Impulses That Cause Anxiety	
Recurrent & Persistent Images That Cause Anxiety		Recurrent & Persistent Dreams That Cause Anxiety	

Comments: _____

Sleep

Normal	Increased	Difficulty Falling Asleep	Decreased
Frequent Awakenings	Sleep Disturbance	Difficulty Waking Up	Tired
Insomnia	Hypersomnia	Difficulty Remaining Asleep	Restless
Unsatisfying Sleep			

Comments: _____

Appetite

Normal	Increased	Decreased	Skipping Meals
Loss of Appetite	Purging	Excessive Hunger	Binge Eating Loss
In Weight	How Much _____		
Gain In Weight	How Much _____		

Comments: _____

Suicidal or Homicidal Ideation

No Suicide Thoughts	Suicidal Without Plan	Suicidal With Plan	Means
No Homicidal Thoughts	Homicidal Without Plan	Homicidal With Plan	Means
Prior Attempts (Dates): _____			
PATIENT IS:	Able To Contract	Contract Verbally	Contract Written
Unable To Contract			

Comments: _____

7.Perceptions:

Hallucinations	Absent	Hallucinations Present	Indicate Type:
Illusions: (An Inaccurate Perception)	Absent	Illusions Present	
Delusions	Absent	Delusions Present	Indicate Type:

8.Thoughts:

Process

Normal for Culture	Logical	Flight Of Ideas	Blocking
(Echolalia) Involuntary Repetition	of Words	Circumstantial	Indecisive
Loose Associations	Hopelessness	Directed	Focused
Incoherence	Neologisms (Newly Invented Words)		Dissociation
Obsessive Thoughts	Disruption of Thought Process / Content		Poor Memory
Poor Concentration			

Comments: _____

Content

Delusions	Phobias	Thoughts Of Running Away	Magical ThinkingFeels
Worthless	Paranoia	Preoccupations	Antisocial
Attitude Obsessions	Compulsions	Ideas Of Reference	Feels Persecuted
Excessive Religiosity	Somatic Complaints	Blames Others	Other

Comments: _____

_____