Family Service: Prevention, Education, & Counseling

Mental Health History Form

Reasons for coming to Family Service:

Have you had any counseling or therapy in the past? ☐ *(Check if you have had counseling or therapy in the past.)*

Are you currently taking any psychiatric medications? ☐ *(Check yes if true.)*

If yes, please list the medications as well as the name and phone number of the prescribing doctor:

Do you have any medical or psychiatric conditions that you think might be influencing the difficulties you have now?
☐ *(Check yes if true.)*

If yes, please explain:

Do you now, or have you in the past, used any of the following substances?

☐ Prescription Drugs	Last Use	How Often
☐ Tobacco	Last Use	How Often
☐ Alcohol	Last Use	How Often
☐ Marijuana	Last Use	How Often
☐ Cocaine	Last Use	How Often
☐ Heroin	Last Use	How Often
☐ Other Narcotics	Last Use	How Often
☐ Acid/ Hallucenogenics	Last Use	How Often

What do you hope to accomplish in therapy?

How long/ how many sessions do you expect this to take?