
MENTAL HEALTH HISTORY/STATUS

What problems are you seeking help for?

NIL

Past Mental Health Treatment

Have you ever been hospitalized for psychiatric reasons? YES NO

If yes, when and where?

Have you ever had outpatient treatment by a psychiatrist? YES NO

If yes, when and by whom?

Have you ever received counseling or psychotherapy in the past? YES NO

If yes, when and by whom?

Please List any psychiatric medication you have taken or are taking:

Medication

Date

Side Effects/Benefits

- NIL

Please Check all that apply:

- | | | |
|---|--|--|
| <input type="checkbox"/> Depressed mood | <input type="checkbox"/> Excessive talking | <input type="checkbox"/> Unreasonable fear |
| <input type="checkbox"/> Lost or gained weight | <input type="checkbox"/> Racing thoughts | <input type="checkbox"/> Fear of social situations |
| <input type="checkbox"/> Not enough sleep | <input type="checkbox"/> Easily distracted | <input type="checkbox"/> Repetitive thoughts/behavior |
| <input type="checkbox"/> Too much sleep | <input checked="" type="checkbox"/> Over working yourself | <input type="checkbox"/> Upsetting memories |
| <input type="checkbox"/> Sluggish | <input type="checkbox"/> Impulsive behavior | <input type="checkbox"/> Recent loss/grief |
| <input type="checkbox"/> Agitated | <input type="checkbox"/> See/hear things that are not real | <input checked="" type="checkbox"/> Work/school problems |
| <input type="checkbox"/> Never tired | <input type="checkbox"/> Suspect things may not be real | <input type="checkbox"/> Violent thoughts/behaviors |
| <input type="checkbox"/> Cannot concentrate | <input type="checkbox"/> Tense/unable to relax | <input type="checkbox"/> Self harm |
| <input type="checkbox"/> Afraid to leave home | <input type="checkbox"/> Excessive worry | <input type="checkbox"/> Anger outburst |
| <input type="checkbox"/> Inflated self esteem | <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Careless, high-risk behavior |
| <input type="checkbox"/> Feel guilty or worthless | <input type="checkbox"/> Thoughts of death or suicide | <input checked="" type="checkbox"/> Financial problems |

GENERAL MEDICAL HISTORY

Primary Care Physician:

Please list any medical problems you may have below:

HIGH BLOOD PRESSURE

Please list any serious medical procedures you have had in the past:

NIL

-

Are you on any medications for any general medical problems you may have? YES NO

If yes, which ones? HIGH BLOOD PRESSURE

Do you have any allergies to medications? YES NO

If yes, which ones?

Did you have any early development problems as a child?

NO

Are you/were you a victim of any form of physical/sexual/emotional abuse?

NO

Highest Level of Education: **BACHELOR'S DEGREE**

Please list the last three jobs you have had below:

VISUAL ARTIST

CHURCH ADMINISTRATOR

SCHOOL SPECIALIST

Current employment: **ELEMENTARY SCHOOL SPECIALIST WITH A FOSTER AGENCY**

Are you currently in a romantic relationship? **YES** **NO** Duration: _____

Describe your relationship:

MARITAL

Spouse or partner's current occupation: **CIVIL SERVANT**

Do you have any children? YES NO How many? 3

What are your children's names and ages?

OLUWAPELUMI DADA - 18 YEARS

OLUWAPELUMI DADA - 16YEARS

OLUWAPELUMI DADA - 11 YEARS

What activities do you enjoy doing?

BIBLE TAECHING,

COUNSELING AND

PAINTING

Have you ever been convicted of any crimes, served time, or been on probation? YES NO

Details:

Please list any additional notes that you think would be helpful for treatment below:

NIL
