Dr. Laura Beth COOPER

Laura Beth Cooper, Ph.D.

Mental and Physical Health Questionnaire

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Current Symptoms (Check symptoms you have recently experienced)

____ Depressed Mood	____ Loss of Interest	____ Sleep Disturbances
____ Appetite Changes	____ Avoidance	____ Crying Spells
____ Feelings of Guilt	____ Unable to enjoy activities	____ Fatigue
____ Feelings of Helplessness	____ Feelings of Worthlessness	____ Low Self-Esteem
____ Feelings of Hopelessness	____Thoughts of Death	____ Suicidal Thoughts
____ Racing Thoughts	____ Excessive Worry	____ Self-Harm Behaviors
____ Concentration Problems	____ Impulsivity	____ Homicidal Thoughts
____ Feelings of Panic	____ Frequent Mood Swings	____ Increased Risky Behavior
____ Hallucinations	____ Excessive Energy	____ Increased Irritability
____ Feeling Keyed Up or On Edge	____ Gastrointestinal Upset	____ Headaches

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Have you ever participated in outpatient therapy? ____ Yes ____ No If yes, please provide names and approximate treatment dates for each provider seen in the space below.

Provider: ________________________________ Dates: ___________________ Successful? _______

Provider: ________________________________ Dates: ___________________ Successful? _______

Provider: ________________________________ Dates: ___________________ Successful? _______

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Have you ever had inpatient treatment for psychiatric purposes? ____ Yes ____ No If yes, please provide the name(s) of the treatment facilities and the approximate dates for each stay.

Facility: ________________________________ Dates: ___________________ Successful? _______

Facility: ________________________________ Dates: ___________________ Successful? _______

Facility: ________________________________ Dates: ___________________ Successful? _______

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Have you ever been diagnosed with any mental health conditions? ____ Yes ____ No If yes, please list all diagnoses below:

Diagnosis: _____________________________ Date: ________________ By Whom? _____________

Diagnosis: _____________________________ Date: ________________ By Whom? _____________

Diagnosis: _____________________________ Date: ________________ By Whom? _____________

Please list all psychotropic medications (with dosages) that you are currently being prescribed.

Medication: ___________________ Dosage: __________ Approximate date you began med.: _________

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Medication: ___________________ Dosage: __________ Approximate date you began med.: _________

Who currently prescribes this medication? ____

Have you ever attempted suicide? ____ Yes ____ No If yes, when? ___________________________

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Physical Health Information

Do you have significant physical health problems? ____ Yes ____ No If yes, what? ______________

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Are there significant medical issues in your family? ____ Yes ____ No If yes, what? _______________

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Do you participate in regular exercise/sports/recreation (about 3 times a week) ____ Yes ____ No

Are you on a special diet for weight loss or any other reason (to lower cholesterol, control diabetes, etc.?

____ Yes ____ No If yes, what are your nutritional requirements? ______________________________

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How often in a day do you drink beverages that contain caffeine, including soda, coffee, tea or energy drinks? ____

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Substance Use History

Do you smoke cigarettes? ____ Yes ____ No If yes, # per day _____

How often do you drink alcohol (Please circle your answer)

A. I do not drink alcohol B. About once a month C. 2 to 3 times a month

D. 2 to 3 times a week E. Once a day or more

On days that you drink, how many servings of beer/wine/liquor do you consume? ___________________

How often in the past month have you used illicit drugs? (Please circle your answer)

A. I do not use drugs at all B. About once a month C. 2 to 3 times a month

D. 2 to 3 times a week E. Once a day or more

Please list the names of any illicit drugs and the quantity consumed: ______________________________

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Have you ever been hospitalized for chemical dependency treatment? ____ Yes ____ No If yes, please provide the name(s) of the treatment facilities and the appropriate dates for each stay.

Facility: ____ Dates: _______________________________

Facility: ____ Dates: _______________________________

Facility: ____ Dates: _______________________________

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Family Background

Where were you born? _______________________ Where did you grow up? _____________________

Were you adopted? ____ Yes ____ No

Father's Name: ________________________ Age: _____ Occupation: _________________________

Mother's Name: ________________________ Age: _____ Occupation: _________________________

Siblings names and ages: ____

____

Did your parents divorce? ____ Yes ____ No If yes, how old were you when they divorced? _______

If your parents divorced, whom did you live with? ____

Are you currently: _____ Married _____ Partnered _____ Divorced ______ Single ______ Widowed

If you are not married, are you currently in a relationship? ____ Yes ____ No If yes, how long? _____

What is your spouse or significant other's occupation? ____

Describe the relationship with your spouse or significant other: ____________________________________

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Do you have any children: _____ Yes ____ No If yes, list names and ages: _____________________

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Describe the relationship with your children: ____

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Educational/ Occupational/ Legal Background

Education – Years completed or highest degree earned ____

Military Service: ____ Yes ____ No How long? __________ Rank _____________________________

Employer name: ____________________________ Length of employment: ________________________

Recent/current legal issues? ____ Yes _____ No If yes, please provide a description of legal issues:

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Are there any other concerns that you wish to share with your therapist? __________________________

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