Carolina Psychological Health Mental Health Questionnaire

✷ *Instructions: Please answer <u>all</u> questions accurately* ✷

Personal Information ✎

Last Name:		First Name:	Middle Initial:	SSN: - -
Age:	Date of Birth: / /	Race:		Insurance Carrier:
Personal Phone Number: ( ) -		Email Address:		Physical Address:
Emergency Point of Contact Name:				Telephone Number: ( ) -
Primary Care Manager/Practice:				Telephone Number: ( ) -

Relationship History ✎

Marital Status	❑ Single ❑ Engaged ❑ Married ❑ Separated ❑ Divorced ❑ Widowed
Engagements	❑ 0 ❑ 1st __ years, ❑ 2nd __ years, ❑ 3rd __ years, ❑ 4th __ years ❑ > 4
Marriages	❑ 0 ❑ 1st __ years, ❑ 2nd __ years, ❑ 3rd __ years, ❑ 4th __ years ❑ > 4
Children	❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ >5 ❑ **Stepchildren** ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ >5 ❑
Orientation	❑ Straight ❑ Lesbian ❑ Bisexual ❑ Transgender ❑ Questioning ❑ Asexual

Statement	**Answer**	**Dates Occurred**
Domestic and/or child abuse has occurred in my home.	Yes ❑ No ❑	-
I have been involved in a family advocacy – social services case.	Yes ❑ No ❑	-
I have been charged with domestic/child/elder abuse.	Yes ❑ No ❑	-

Educational History ✎

I completed the following education…

School	**Completion**	Degree Attained	Cumulative GPA
Grade School	Yes ❑ No ❑		
High School	Yes ❑ No ❑		
General Equivalency Degree	Yes ❑ No ❑		
Vocational Training Certification	Yes ❑ No ❑		
Technical College Degree	Yes ❑ No ❑		
Associate's Degree	Yes ❑ No ❑		
Bachelor's Degree	Yes ❑ No ❑		
Master's Degree	Yes ❑ No ❑		
Doctorate	Yes ❑ No ❑		

I had to repeat a grade in elementary, middle and/or high school.	Yes ❑ No ❑ Grade Repeated: ____
I participated in special education classes.	Yes ❑ No ❑
I was home schooled.	Yes ❑ No ❑
I was suspended # times in school.	❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ > 4
I was expelled # times in school.	❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ > 4

Employment History ✎

List the types of jobs, how long you were at each, and reason you left. ❑ **N/A**

Job Title	**Employer**	**Employment Dates**	**Reason for Leaving**
		-	
		-	
		-	
		-	
		-	

I have been on SSI/disability Yes ❑ No ❑ I am currently filing for SSI/disability Yes ❑ No ❑

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Military Service History ✎

Please specify your military history as applicable.		❑ **N/A**
Years of Service:	Projected Rotation Date:	End of Obligated Service:
Occupational Specialty:	Highest Rank Achieved:	Retirement Date:
I have been in the military less than 1 year.		Yes ❑ No ❑
I am presently working in an area related to my military training.		Yes ❑ No ❑
I have been aero medically evacuated from theater.		Yes ❑ No ❑
I am currently or have been on Limited Duty.		Yes ❑ No ❑
I am pending a Medical Board or Administrative Separation		Yes ❑ No ❑
I have received Non-Judicial Punishment or Courts Martial		Yes ❑ No ❑
I have been evaluated by either SACO, SARD or DAPA		Yes ❑ No ❑
I have been medically retired with a DoD rating of ___% and VA rating of ___ % as of ____ (Date)		

Military Service Time Line

Duty Status		Dates Started/Ended	Parent Command	Geographical Location	Combat Action
Service Entry Date:					
Recruit/Basic Training:		-			
MCT/SOI/TBS/OIS:	N/A ❑	-			
MOS training:	N/A ❑	-			
2nd MOS Training	N/A ❑	-			
1st Duty Station:		-			
2nd Duty Station:	N/A ❑	-			
3rd Duty Station:	N/A ❑	-			
4th Duty Station:	N/A ❑	-			
5th Duty Station:	N/A ❑	-			
6th Duty Station:	N/A ❑	-			
7th Duty Station:	N/A ❑	-			
1st Deployment:	N/A ❑	-			Yes ❑ No ❑
2nd Deployment:	N/A ❑	-			Yes ❑ No ❑
3rd Deployment:	N/A ❑	-			Yes ❑ No ❑
4th Deployment:	N/A ❑	-			Yes ❑ No ❑
5th Deployment:	N/A ❑	-			Yes ❑ No ❑

If exposed to combat/trauma, please specify exposure as below:

❑ Fire fight(s)	❑ WIA(s)	❑ Exposure to corpse(s)
❑ Mortar attack(s)	❑ Lost friend(s) in combat	❑ Prisoner of war
❑ IED attack(s)	❑ Military sexual trauma(s)	❑ Other:
❑ KIA(s)	❑ Exposure to blood/trauma(s)	❑ Other:

Legal History ✎

Are you currently or have you had a history of civilian legal problems?			❑ **N/A**
Offense/Charge	**Date of Charge**	**Conviction**	**Current Legal Status**
		Yes ❑ No ❑	Open ❑ Resolved ❑
		Yes ❑ No ❑	Open ❑ Resolved ❑
		Yes ❑ No ❑	Open ❑ Resolved ❑

Spiritual Assessment ✎

My spiritual belief system is important to me.	Yes ❑ No ❑
I do not wish to talk about my spiritual belief system.	Yes ❑ No ❑
I would like to augment my care with spiritual support services.	Yes ❑ No ❑
I have lost my spiritual faith.	Yes ❑ No ❑

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Personal/Family History ✎

Born in (Location):	Raised in (Location):	Raised by:	
During my birth/infancy/childhood I…			
was premature	Yes ❑ No ❑	missed developmental milestones	Yes ❑ No ❑
had birth complications	Yes ❑ No ❑	received corporal punishment	Yes ❑ No ❑
had birth defects	Yes ❑ No ❑	demonstrated behavioral problems	Yes ❑ No ❑
had a drug dependent parent	Yes ❑ No ❑	saw developmental specialists	Yes ❑ No ❑
was not cared for by parents	Yes ❑ No ❑	was abused and/or neglected	Yes ❑ No ❑
Parents current marital status:	❑ Married	❑ Separated ❑ Divorced	❑ Widowed
Number of siblings:	__ Brothers	__ Sisters __ Step brothers	__ Step sisters
Your age when parent(s) died? __ Mother __ Father ❑ N/A		*Your age when parents divorced?* __ ❑ N/A	
Prior to this evaluation, I was …			
in foster care	Yes ❑ No ❑	arrested/Incarcerated	Yes ❑ No ❑
adopted	Yes ❑ No ❑	under court mandated care	Yes ❑ No ❑
homeless	Yes ❑ No ❑	in a residential group home	Yes ❑ No ❑
in juvenile detention	Yes ❑ No ❑	in drug rehabilitation	Yes ❑ No ❑

I have experienced problems with the following …

Behavior	***Answer***	***Ages***	***Behavior***	***Answer***	***Ages***
Stuttering	Yes ❑ No ❑		Bullying/threatening behavior	Yes ❑ No ❑	
Bed Wetting	Yes ❑ No ❑		Physical cruelty to animals	Yes ❑ No ❑	
Unreasonable Fears	Yes ❑ No ❑		Physical cruelty to people	Yes ❑ No ❑	
Nightmares	Yes ❑ No ❑		Starting fires for amusement	Yes ❑ No ❑	
Sleepwalking	Yes ❑ No ❑		Intentional Violation of the law	Yes ❑ No ❑	
Depression	Yes ❑ No ❑		Destruction of property	Yes ❑ No ❑	
Anxiety	Yes ❑ No ❑		Used weapons intent to harm	Yes ❑ No ❑	
Panic Attacks	Yes ❑ No ❑		Experienced abuse/trauma	Yes ❑ No ❑	
Suicidal Thoughts	Yes ❑ No ❑		Obsessive Compulsive Behavior	Yes ❑ No ❑	
Inattention	Yes ❑ No ❑		Paranoid & Suspicious Thoughts	Yes ❑ No ❑	
Impulsivity	Yes ❑ No ❑		Hallucinations	Yes ❑ No ❑	
Impaired Sleep	Yes ❑ No ❑		Hyper Sexuality	Yes ❑ No ❑	

Prior to today, I received the following mental health care: **❑ N/A**

Type of Care	***Answer***	**Treatment Dates**	**Mental Health Provider**
Individual/School Counseling	Yes ❑ No ❑	-	
Psychiatric Medication Therapy	Yes ❑ No ❑	-	
Psychiatric Crisis Intervention	Yes ❑ No ❑	-	
Inpatient Psychiatric Hospitalization	Yes ❑ No ❑	-	
Court Mandated Psychiatric Care	Yes ❑ No ❑	-	
Psychiatric Day Treatment	Yes ❑ No ❑	-	
Eating Disorder Treatment	Yes ❑ No ❑	-	
Inpatient Substance Rehabilitation	Yes ❑ No ❑	-	
Outpatient Substance Rehabilitation	Yes ❑ No ❑	-	

In either the past or presently, I have/am experienced/experiencing… **❑ N/A**

Problem	**Answer**	**Time Period Occurred**	**Current Status**
Suicidal Thoughts	Yes ❑ No ❑	-	Resolved ❑ Unresolved ❑
Suicidal Behavior	Yes ❑ No ❑	-	Resolved ❑ Unresolved ❑
Suicide Attempt	Yes ❑ No ❑	-	Resolved ❑ Unresolved ❑
Intentional Self-Mutilation	Yes ❑ No ❑	-	Resolved ❑ Unresolved ❑
Aggressive Behavior	Yes ❑ No ❑	-	Resolved ❑ Unresolved ❑
Homicidal Thoughts	Yes ❑ No ❑	-	Resolved ❑ Unresolved ❑
Homicidal Behavior	Yes ❑ No ❑	-	Resolved ❑ Unresolved ❑
Homicide Attempt	Yes ❑ No ❑	-	Resolved ❑ Unresolved ❑
Intentionally Reckless Behavior	Yes ❑ No ❑	-	Resolved ❑ Unresolved ❑

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Medical History ✎

Food/Drug Allergies:	Food/Drug Allergy Reaction:	Date(s) of Occurrence
For example, "Penicillin"	*Hives*	*2006*

Condition	Answer	Date(s) Occurred	Current Status
History of Seizure	Yes ❑ No ❑		Resolved ❑ Unresolved ❑
History of Concussion	Yes ❑ No ❑		Resolved ❑ Unresolved ❑
History of Loss of Consciousness	Yes ❑ No ❑		Resolved ❑ Unresolved ❑
History of Coma	Yes ❑ No ❑		Resolved ❑ Unresolved ❑
History of Traumatic Brain Injury	Yes ❑ No ❑		Resolved ❑ Unresolved ❑
History of Thyroid Disorder	Yes ❑ No ❑		Resolved ❑ Unresolved ❑

I am <u>currently</u> taking the following medications… ❑ **N/A**

Medication	Dose	Frequency	Reason for Use	Date Started
For example, "Motrin."	*650mg*	*3x daily*	*Back pain*	*2012*

If > 3 medications please attach a list of all current medications you are taking to this screening packet.

I am <u>currently</u> taking the following supplements… ❑ **N/A**

Supplement	Dose	Frequency	Reason for Use	Date Started
				-
				-
				-

If > 3 supplements please attach a list of all current medications you are taking to this screening packet.

I have taken the following PSYCHIATRIC medications <u>in the past</u>… ❑ **N/A**

Medication	Dose	Frequency	Reason for Use	Date Discontinued
For example, "Prozac"	*40mg*	*Daily*	*Depression*	*2010 -2011*
				-
				-
				-

If > 3 medications please attach a list of all current medications you are taking to this screening packet.

I am <u>currently</u> experiencing the following MEDICAL/SURGICAL problems… ❑ **N/A**

Problem	Duration of Problem	Current Status
For example, "Hypertension."	*2012 - current*	Stable ☑ Unstable ❑ Resolved ❑
	-	Stable ❑ Unstable ❑ Resolved ❑
	-	Stable ❑ Unstable ❑ Resolved ❑
	-	Stable ❑ Unstable ❑ Resolved ❑
	-	Stable ❑ Unstable ❑ Resolved ❑

I have experienced the following MEDICAL/SURGICAL problems <u>in the past.</u> ❑ **N/A**

Medical/Surgical Problem	Duration of Problem	Current Status
For example, "Appendectomy."	*2012*	Stable ❑ Unstable ❑ Resolved ☑
	-	Stable ❑ Unstable ❑ Resolved ❑
	-	Stable ❑ Unstable ❑ Resolved ❑
	-	Stable ❑ Unstable ❑ Resolved ❑

Members of my family have the following mental health and/or substance use history ❑ **N/A**

Family Member	Condition/Diagnosis	Treatment
For example, "maternal aunt."	*"schizophrenia"*	*"Haldol and hospitalization"*

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Lifestyle/Habits Assessment ✎

Over the past year my use of the following substances has been as follows				❑ **N/A**
Caffeinated drinks/day:	❑ Don't Use	❑ 1 – 3/day	❑ 3 – 6/day	❑ > 6/day
Smokeless tobacco "dips"/day	❑ Don't Use	❑ ≤ ½ can/day	❑ 1 can/day	❑ > 1 can/day
Cigarettes/day	❑ Occasional	❑ ≤ ½ pack/day	❑ 1 pack/day	❑ > 1pack/day
Alcohol of choice is:	❑ Don't Use	❑ Beer	❑ Wine	❑ Liqueur
# Alcohol drinks/episode	❑ 0	❑ 1 - 3	❑ 3 - 6	❑ > 6/day
# Alcohol drinking episodes/week:	❑ 0	❑ 1 - 3	❑ 3 - 6	❑ > 6/day
Recreational/Illicit drugs:	**❑ No history**	**(P) In the past**	**(R) Recently**	**(C) Currently**
I have experimented with the following. Please place either (P), (R) or (C) after the substance that you have used. (e.g. ☑ Marijuana (P))	❑ Marijuana __ ❑ Mescaline __ ❑ Heroin __ ❑ Cocaine __ ❑ Ecstasy __ ❑ Special K __	❑ Spice __ ❑ Bath Salts __ ❑ Opium __ ❑ Amphetamine __ ❑ Rohypnol __ ❑ Salvia __	❑ LSD __ ❑ Inhalants __ ❑ Methadone __ ❑ Crystal Meth __ ❑ GHB __ ❑ Xanax __	❑ Mushrooms __ ❑ Steroids __ ❑ Suboxone __ ❑ PCP __ ❑ DXM __ ❑ OxyContin __

AUDIT Question	**Response**			
Do you feel you are a normal drinker?	Yes: 0	❑	No: 2	❑
Do friends or relatives think you are a normal drinker?	Yes: 0	❑	No: 2	❑
Have you ever attended a meeting of Alcoholics Anonymous?	Yes: 5	❑	No: 0	❑
Have you ever lost friends girlfriends or boyfriends because of drinking?	Yes: 2	❑	No: 0	❑
Have you ever gotten in trouble at work because of drinking?	Yes: 2	❑	No: 0	❑
Have you ever neglected your obligations, family or work for 2 or more days in a row because you were drinking?	Yes: 2	❑	No: 0	❑
Have you ever had delirium tremens (DTs) had severe shaking heard voices or seen things that weren't there after heavy drinking?	Yes: 2	❑	No: 0	❑
Have you ever gone to someone for help about your drinking?	Yes: 5	❑	No: 0	❑
Have you ever been in a hospital because of drinking?	Yes: 5	❑	No: 0	❑
Have you ever been arrested for drunk driving or driving after drinking?	Yes: 2	❑	No: 0	❑

Adverse Childhood Experience (ACE) Questionnaire

Question	Answer
1. Did a parent or other adult in the household often… swear at you, insult you, put you down or humiliate you? Or, Act in a way that made you afraid that you might be physically hurt?	Yes ❑ No ❑
2. Did a parent or other adult in the household often… push, grab, slap or throw something at you? Or, Ever hit you so hard that you had marks or were injured?	Yes ❑ No ❑
3. Did an adult or person at least 5 years older than you ever… Touch or fondle you or have you touch their body in a sexual way? Or, Try to or actually have oral, anal, vaginal sex with you?	Yes ❑ No ❑
4. Did you often feel that… No one in your family loved you or thought you were important or special? Or, Your family didn't look out for each other, feel close to each other or support each other?	Yes ❑ No ❑
5. Did you often feel that… You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? Or, Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?	Yes ❑ No ❑
6. Were your parents ever separated or divorced?	Yes ❑ No ❑
7. Was your mother or stepmother… Often pushed, grabbed, slapped, or had something thrown at her? Or, Sometimes or often kicked, bitten, hit with a fist, or hit with something hard? Or, Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?	Yes ❑ No ❑
8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?	Yes ❑ No ❑
9. Was a household member depressed or mentally ill or did a household member attempt suicide?	Yes ❑ No ❑
10. Did a household member go to prison?	Yes ❑ No ❑

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Current Problem ✎

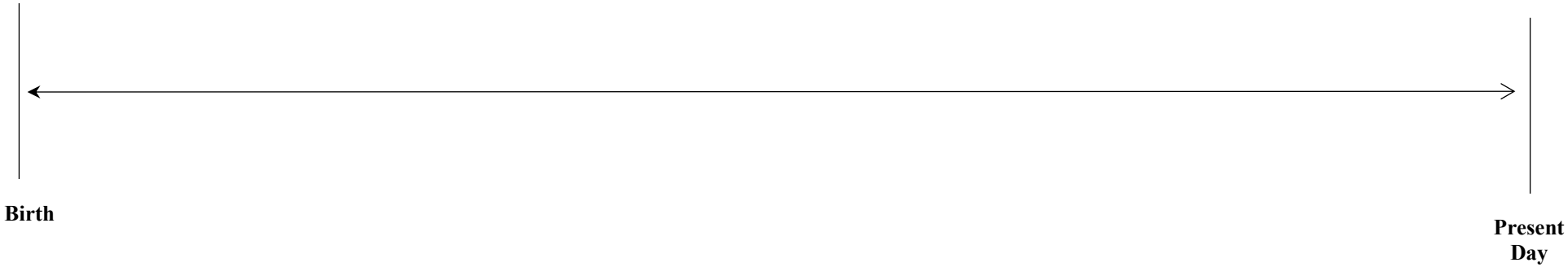
We are concerned and interested in why you are here today – Please tell us.

1. Please list out your symptoms and stressors below:

Symptom	Duration	Life Stressor	Duration
For example, "depression"	*4 months*	*Divorce*	*1 year*

Critical Life Event Timeline

Please construct a critical life event timeline in the space below. Critical life events include but are not limited to things like: (1) Birth, (2) Abuse/Trauma, (3) School, (4) Leaving Home, (5) Marriage, (6) Birth of Children, (7) Military Service/Deployments, (8) Important losses, (9) Divorce, (10) Onset of psychiatric symptoms, (11) Legal Cases, (12) Hospitalizations & (13) Changes in health status. Please include dates with events.



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*STOP HERE * DO NOT FILL THIS OUT*

Suicide Assessment Five – Step Evaluation and Triage (SAFE-T) Tool

Risk Factors		Protective Factors	
Suicidal Behavior		**Internal**	
History of prior suicide attempt	Yes ❑ No ❑	Ability to Cope with Stress	Yes ❑ No ❑
Aborted suicide attempt	Yes ❑ No ❑	Established Religious Beliefs	Yes ❑ No ❑
Past self-injurious behavior	Yes ❑ No ❑	Frustration Tolerance	Yes ❑ No ❑
Current/Past Psychiatric Disorders		**External**	
Depressive Disorder	Yes ❑ No ❑	Responsibility to children/pets	Yes ❑ No ❑
Bipolar Spectrum Disorder	Yes ❑ No ❑	+ Therapeutic Relationship	Yes ❑ No ❑
Schizophrenia Spectrum Disorder	Yes ❑ No ❑	+ Social Support System	Yes ❑ No ❑
Substance Use Disorder	Yes ❑ No ❑	**Suicide Inquiry**	
Attention-Deficit/Hyperactivity Disorder	Yes ❑ No ❑	Ideation	Yes ❑ No ❑
Traumatic Brain Injury	Yes ❑ No ❑	Plan	Yes ❑ No ❑
Post-Traumatic Stress Disorder	Yes ❑ No ❑	Behaviors	Yes ❑ No ❑
Personality Disorder	Yes ❑ No ❑	Intent	Yes ❑ No ❑
Conduct Disorder	Yes ❑ No ❑	**Risk Level**	
Medical Comorbidity	Yes ❑ No ❑	High:	Yes ❑ No ❑
New Onset Medical Illness	Yes ❑ No ❑	Moderate:	Yes ❑ No ❑
Key Symptoms		Low	Yes ❑ No ❑
Anhedonia	Yes ❑ No ❑	**Notes**	
Impulsivity	Yes ❑ No ❑		
Hopelessness	Yes ❑ No ❑		
Anxiety	Yes ❑ No ❑		
Panic	Yes ❑ No ❑		
Insomnia	Yes ❑ No ❑		
Command Hallucinations	Yes ❑ No ❑		
Family History			
Suicide Gesture/Attempt/Completion	Yes ❑ No ❑		
ψ Diagnosis with Hospitalization	Yes ❑ No ❑		
Precipitants/Stressors/Interpersonal			
Triggering Event with Humiliation	Yes ❑ No ❑		
Triggering Event with Shame	Yes ❑ No ❑		
Triggering Event with Despair	Yes ❑ No ❑		
Ongoing Medical Illness	Yes ❑ No ❑		
Acute Substance Intoxication	Yes ❑ No ❑		
Family Turmoil/Chaos	Yes ❑ No ❑		
History of Physical or Sexual Abuse	Yes ❑ No ❑		
Social Isolation	Yes ❑ No ❑		
Changes in Treatment			
Discharged from Inpatient Status	Yes ❑ No ❑		
Mental Health Provider Change	Yes ❑ No ❑		
Psychotropic Medication Change	Yes ❑ No ❑		

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Risk Assessment for Violence Toward Others
(Based on the MacArthur Violence Risk Assessment Study, 2005)

Risk Factors		Protective Factors	
Current violent thoughts	Yes ❑ No ❑	No current violent thoughts	Yes ❑ No ❑
Current Intent to harm other	Yes ❑ No ❑	No history of aggressive behavior	Yes ❑ No ❑
Organized plan to harm others	Yes ❑ No ❑	Responsibility to family/friends	Yes ❑ No ❑
Previous violent behavior	Yes ❑ No ❑	Future oriented thinking	Yes ❑ No ❑
Access to lethal means	Yes ❑ No ❑	Social support network	Yes ❑ No ❑
Age between 18 and 24	Yes ❑ No ❑	Rational thinking/frustration tolerance	Yes ❑ No ❑
Male gender	Yes ❑ No ❑	Intact problem solving/coping skills	Yes ❑ No ❑
Past exposure to violence	Yes ❑ No ❑	Religious/spiritual beliefs	Yes ❑ No ❑
Substance abuse history	Yes ❑ No ❑	Motivation for help/Treatment Engagement	Yes ❑ No ❑
Antisocial personality	Yes ❑ No ❑	Impulse Control	
Impulsivity	Yes ❑ No ❑	**Notes**	
Rational thinking loss	Yes ❑ No ❑		
Untreated psychotic symptoms	Yes ❑ No ❑		
Elevated anger/mood instability	Yes ❑ No ❑		
Acute/chronic stressors	Yes ❑ No ❑		

Overall Level of Risk			
No Acute Risk for Violence	Low Acute Risk for Violence	Intermediate Acute Risk for Violence	High Acute Risk for Violence
☐ No action indicated	☐ More protective factors than risk	☐ More risk factors than protective	☐ Several risk factors with little to no protective

***Principle Purposes**: Information will be used to collect from private insurers for medical care provided to military dependents and retirees. Such monetary benefits securing to the Military Medical Facility will be used to enhance health care delivery in the Medical Treatment Facility. Information will also be used by Military Treatment Facility staff and Champus. Fiscal Intermediaries to determine eligibility for care, deductibles and closures.*
***Routine Uses**: The information on this form will be released to your insurance company, and to Medical Treatment Facility Staff, Champus FI's and providers.*
***Disclosure**: Voluntary, however, failure to provide complete and accurate information may result in disqualification for health care services from facilities of the uniformed services and in ah higher cost to you for medical care.*