VA Medical Center
10535 Hospital Way, Mather, CA 95655
Community Living Center (CLC)
150 Muir Road, Martinez, CA 94553
VA Outpatient Clinics:
1601 Concord Ave., Chico, CA 95928
5342 Dudley Avenue, McClellan, CA 95652
201 Walnut Avenue, Mare Island, CA 94592
150 Muir Road, Martinez, CA 94553
2221 Martin Luther King, Jr. Way,
Oakland, CA 94612
351 Hartnell Avenue, Redding, CA 96002

VA Outpatient Clinics (continued):
103 Bodin Circle, Bldg. 778, Travis AFB, CA 94535
425 Plumas Boulevard, Yuba City, CA 95991
11985 Heritage Oak Pl, Ste 100, Auburn, CA 95603
101 East Oberlin Road, Yreka, CA 96097
Oakland Behavioral Health Clinic
525 21st Street, Oakland, CA 94612
Martinez Behavioral Health Clinic
150 Muir Road, Bldg. 24
Martinez, CA 94553
Mather Behavioral Health Clinic
10535 Hospital Way, Building 651
Mather, CA 95655
Telephone Care: 1-800-382-8387
Website: www.northerncalifornia.va.gov/

GENERAL MENTAL HEALTH SERVICES
Behavioral Health Outpatient

Dear Veteran,

Welcome to the VA Behavioral Health Outpatient Clinic.

Please complete the following questionnaire. While you will be interviewed by a mental health specialist, answering these questions will help us to:

- Better assess your current needs.
- Understand the reasons you've chosen to seek mental health care.
- Recommend different types of treatments to assist in your recovery.

The following pages include questions that help us assess your mental health needs, but also take a broader perspective that includes your social and cultural history that help us understand you as a whole person.

Please answer to the best of your ability and knowledge. Please talk directly with your mental health specialist about any questions that you do not know or understand, if you are unable to recall, or if you choose to decline to answer.

Patient Name: _____ Last 4 SSN: _____

Please explain what brings you to our clinic. How can we help you?

_____

_____

_____

OVER THE LAST MONTH, HOW OFTEN HAVE YOU BEEN BOTHERED BY THE FOLLOWING:
(Please check the appropriate box)

Little interest or pleasure in doing things:

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Feeling down, depressed, or hopeless:

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Trouble falling asleep, staying asleep, or sleeping too much:

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Feeling tired or having little energy:

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Poor appetite or over eating:

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Feeling bad about yourself; that you are a failure or that you have let yourself or your family down:

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Trouble concentrating on things, such as reading the newspaper or watching television:

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Moving or speaking so slowly that other people could notice …. or being so fidgety and restless that you have been moving around a lot more than usual:

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Thoughts that you would be better off dead, or of hurting yourself:

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

OVER THE LAST MONTH, HOW OFTEN HAVE YOU BEEN BOTHERED BY THE FOLLOWING:
(Please check the appropriate box)

Feeling nervous, anxious, or on edge:

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Not being able to stop or control worry:

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Worrying too much about different things:

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Trouble relaxing:

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Being so restless that it is hard to sit still:

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Becoming easily annoyed or irritable:

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Feeling afraid as if something awful might happen:

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Have you ever experienced or witnessed a life-threatening event such as assault, rape, seeing someone badly injured or killed, combat, major disasters, or serious accidents? ☐ NO ☐ YES

If YES, have you had any of the following occur in connection with such experience **in the past month**?

Nightmares or unwanted thoughts about the event? ☐ NO ☐ YES

Trying hard not to think about the event; went out of your way to avoid situations that reminded you of it? ☐ NO ☐ YES

Feeling constantly on guard, watchful, or easily startled? ☐ NO ☐ YES

Feeling numb or detached from others, activities, or your surroundings? ☐ NO ☐ YES

That any of the items listed above (e.g., nightmares, intrusive thoughts) are currently causing you significant distress? ☐ NO ☐ YES

PAST PSYCHIATRIC HISTORY

Have you ever been diagnosed with a mental health condition? ☐ NO ☐ YES

If yes, please list: _____

_____

Have you ever been hospitalized for psychiatric reasons? ☐ NO ☐ YES

If yes, how many times_____

If you can remember, please complete below. If more than three Hospitalizations list the first and last two hospitalizations:

Month/Year	How Long	Where	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you **currently** seeing an individual therapist or attending group therapy? ☐ NO ☐ YES

If yes, please indicate: _____

Have you **ever** received psychotherapy or counseling?

Individual: ☐ NO ☐ YES

Length or approximate number of sessions? _____ Year:_____

Group: ☐ NO ☐ YES

Length or approximate number of sessions? _____ Year:_____

If so, what was helpful and not so helpful about past treatment?

_____

_____

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

Medication	Date	Side Effects/Benefits
_____		
_____		
_____		

FAMILY MENTAL HEALTH CARE

Have any of your biological relatives (e.g. parents, grandparents, brothers or sisters, children) had problems with depression, attempted suicide, anxiety, hearing voices, drugs, alcohol, or other mental health problems? ☐ NO ☐ YES

If yes, please explain:_____

_____

_____

SUBSTANCE USE HISTORY:

How many caffeinated beverages do you drink a day?
Coffee _____ Sodas _____ Tea _____ Energy Drinks_____

Tobacco History:

Have you ever smoked cigarettes? ☐ NO ☐ YES

Currently? ☐ NO ☐ YES
How many packs per day on average? _____ How many years? _____

In the past? ☐ NO ☐ YES
How many years did you smoke? _____ When did you quit? _____

Pipe, cigars, or chewing tobacco:

Currently? ☐ NO ☐ YES In the past? ☐ NO ☐ YES

What kind? _____ How often per day on average? _____

How many years? _____ Are you ready to quit at this time? ☐ NO ☐ YES

How often have you had a drink containing alcohol in the past year? Consider a drink a bottle of beer, a glass of wine, a wine cooler, or one cocktail or a shot of hard liquor (like scotch, gin or vodka).

☐ Never ☐ Monthly or less ☐ 2-4 times/month

☐ 2-3 times/week ☐ 4-5 times/week ☐ 6+ days/week

How many drinks did you have on a typical day when you were drinking in the past year?

☐ 1-2 drinks ☐ 3-4 drinks ☐ 5-6 drinks

☐ 7-9 drinks ☐ 10+ drinks

How often did you have 6 or more drinks (4 or more for women) on one occasion in the past year?

☐ Never ☐ Monthly ☐ Daily or almost daily

☐ Weekly ☐ Less than monthly

Have you ever experienced any of the following because of your drinking? Check any that apply.

☐ Blackouts ☐ Shakes ☐ Seizures

☐ DTs ☐ Accidents ☐ DWIs/DUIs

☐ Legal problems ☐ Stomach problems ☐ Liver problems

☐ Relationship problems ☐ Job loss/probation

Have you attended any alcohol treatment programs? ☐ NO ☐ YES

If yes, when was the last time, where, and how long?

_____

_____

Check if you have ever tried the following:

YES	NO		If yes, how long, how much, and date last used:
☐	☐	Cocaine	
☐	☐	Stimulants (pills)	
☐	☐	Heroin	
☐	☐	LSD or Hallucinogens	
☐	☐	Marijuana	
☐	☐	Methamphetamines	
☐	☐	Pain killers (not as prescribed)	
☐	☐	Methadone	
☐	☐	Tranquilizer/sleeping pills	
☐	☐	Ecstasy	
☐	☐	IV Drugs	
☐	☐	Other:_____	

Have you attended any substance treatment programs? ☐ NO ☐ YES
If yes, when was the last time, where, and how long?

_____
_____

Check if substance use caused problems in any of the following?

YES	NO		If yes, please explain:
☐	☐	Legal	
☐	☐	Job Related	
☐	☐	Relationships	
☐	☐	Financial	
☐	☐	Housing	
☐	☐	Other: _____	

Check if you ever taken or been prescribed the following medications?

YES	NO		If yes, date last used and current amount per week:
☐	☐	Benzodiazepines	
☐	☐	Opiates	
☐	☐	Stimulants	
☐	☐	Prescription sleep aids	
☐	☐	Medical Marijuana	

Are you concerned about your use of alcohol, drugs, or prescription medications? ☐ NO ☐ YES

HISTORY OF HOMICIDAL and/or SUICIDAL BEHAVIORS

In the last 3 months, have you had any thoughts of hurting yourself? ☐ NO ☐ YES

. . . . or hurting someone else? ☐ NO ☐ YES

If yes, explain_____

_____

Have you ever attempted suicide? ☐ NO ☐ YES

If yes, how many times? _____ When was your last attempt? _____

What did you do and what happened?

_____

_____

How many hospitalizations (medical or psychiatric) are due to suicide attempts? _____

PHYSICAL HEALTH HISTORY

Do you currently receive medical care outside of the VA? ☐ NO ☐ YES

If so, where: _____

List any major medical problems:

_____

_____

List any non-VA prescribed medications and dosages you are currently taking:

_____

_____

NUTRITION:

Do you have any food allergies? ☐ NO ☐ YES

If so, please describe: _____

Have you lost or gained ten pounds or more in the last 3 months? ☐ NO ☐ YES

Have you had a decrease in appetite or amount of food you are eating? ☐ NO ☐ YES

If so, please describe: _____

Do you have any dental problems? ☐ NO ☐ YES

If so, please describe: _____

Do you have disordered eating habits (example: bingeing, self-induced vomiting)? ☐ NO ☐ YES

If so, please describe: _____

CHRONIC PAIN:

Are you in any pain at this time? ☐ NO ☐ YES

Please rate your pain on a scale of 1 through 10, where 10 is the most severe: _____

Where is your pain? _____

YOUR PERSONAL HISTORY

CHILDHOOD AND EARLY YEARS:

In general, my childhood was:_____

Who raised you? _____

Age and gender of any brothers or sisters:_____

How were you disciplined? _____

Witnessed or experienced physical, emotional or sexual abuse in childhood? ☐ NO ☐ YES

HOUSING

Where do you live at this time?

☐ House ☐ Family care home ☐ Apartment ☐ Halfway House

☐ Mobile home ☐ Homeless ☐ Hotel or Motel room ☐ Board and Care

☐ Nursing home ☐ Other (describe) _____

Is homelessness a current concern? ☐ NO ☐ YES

List everyone who currently lives with you:_____

_____

Do you feel safe at home? ☐ NO ☐ YES

MARRIAGE AND RELATIONSHIPS

Has a romantic partner of yours ever threatened to hurt you, a family member, or a pet? ☐ NO ☐ YES

Have you ever physically hurt a family member or a pet? ☐ NO ☐ YES

What best describes your sexual orientation / gender identification?

☐ straight ☐ lesbian/gay ☐ bisexual ☐ transgender ☐ queer

☐ unsure/questioning ☐ other _____ ☐ prefer not to answer

By which pronoun do you prefer to be addressed? He/Him, She/Her, They/Them, other _____

What is your current relationship status?

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Partnered

How long? _____

If not married, are you currently in a relationship? ☐ NO ☐ YES If yes, how long? _____

Describe your relationship with your spouse or significant other: _____

_____

_____

Have you had any prior marriages? ☐ NO ☐ YES If so, how many? _____

How long? _____

Do you have children? ☐ NO ☐ YES

If yes, list ages and gender: _____

_____

_____

Describe your relationship with your children:_____

_____

_____

LOSSES/BEREAVEMENT

In your lifetime, have you experienced a significant loss such as the death of a loved one, loss of a job, or the ending of an important relationship? ☐ NO ☐ YES If yes, please describe:

_____

_____

EDUCATION AND WORK HISTORY

Check any of the following received:

☐ GED ☐ Junior College Degree ☐ College Degree (4yr.)

☐ High school diploma ☐ Tech/Business School Cert. ☐ Graduate school degree

Did you have any of the following problems in school?

☐ No problems ☐ Truancy/absenteeism ☐ Alcohol/Drug use

☐ Fighting, attacking people ☐ Sexual problems ☐ Disturbing class

☐ Other (specify)_____

Did you ever have any problems in learning? ☐ NO ☐ YES

If yes, explain_____

Did you ever repeat a school year (held back)? ☐ NO ☐ YES

If yes, explain_____

Check the item(s) below the best describe you:

☐ Working full-time ☐ Working part-time, # of hours____ ☐ Self- employed

☐ Unemployed but looking for work ☐ Unemployed and not looking for work ☐ Disabled

☐ Retired ☐ Other (e.g., homemaker, volunteer): _____

Have you had difficulty holding a steady job since your military service? ☐ NO ☐ YES

If yes, please explain: _____

_____

What kind of work do you do when you are working? _____

When did you last work? _____ How long? _____

SOCIAL SUPPORT AND LEISURE

Do you have close relative(s) or friend(s) you can rely on for help in times of need? ☐ NO ☐ YES

Do your family and/or friends know you are seeking mental health care? ☐ NO ☐ YES

If no, please comment: _____

What do you do for fun or to relax? _____

CULTURAL/SPIRITUAL HISTORY

How would you describe your cultural background or ethnicity? _____

_____

Where were you born and raised? _____

Do you speak any other languages? Do you have a preferred language besides English?

_____

Do you consider yourself a religious or spiritual person? _____

What is your faith tradition or religion? _____

How important is your religious or spiritual beliefs in your daily life? _____

_____

Are you a member of a church or faith community? ☐ NO ☐ YES

How do your spiritual or religious beliefs apply to your health, if at all? _____

_____

FINANCES

How do you support yourself financially? (Check all that apply):

☐ Salary	☐ Retirement	☐ Veterans compensation or pension
☐ SSI	☐ SSA	☐ General Assistance
☐ Family support	☐ No income	☐ Unemployment
☐ Spouse	☐ Other explain)_____	

Are you currently having serious financial problems? ☐ NO ☐ YES

Do you access community resources (for example Food Stamps, HUD housing, etc.) ☐ NO ☐ YES

If yes, which community resources: _____

_____

LEGAL HISTORY

Have you ever been arrested or charged? ☐ NO ☐ YES

If yes, please explain: _____

Are you currently on probation, parole or awaiting charges or sentencing? ☐ NO ☐ YES

If yes, please explain: _____

Have you ever been in jail or prison? ☐ NO ☐ YES

If yes, please explain: _____

Have you had any other legal problems (civil or criminal) in the past? ☐ NO ☐ YES

If yes, please explain: _____

ACTIVITIES OF DAILY LIVING/SELF-CARE

Do you have difficulties in any of the following? (Check all that apply.)

☐ Bathing	☐ Cooking	☐ Cleaning
☐ Laundry	☐ Shopping (Grocery/Clothes)	☐ Eating
☐ Managing finances	☐ Taking medications	☐ Dressing
☐ Talking on the phone	☐ Getting transportation	☐ Other_____

Please describe what difficulties you are having with each one circled:_____

_____

_____

MILITARY HISTORY

Branch of Service: _____ Highest Rank: _____ Job Title: _____

Date entered Service: _____ Date Discharged: _____ Type of Discharge: _____

Were you drafted? ☐ NO ☐ YES

Did you have any disciplinary actions taken against you? ☐ NO ☐ YES

If yes, what action? _____

_____

Did you serve in a combat zone? ☐ NO ☐ YES If yes, when/where/length?

_____

Were you subject to enemy fire? ☐ NO ☐ YES

Are you troubled today by any of the experiences you had in the military? ☐ NO ☐ YES

If yes, explain_____

_____

MILLENIUM ACT

Congress passed a bill (Millennium Act) that includes provisions for expanding services to veterans (male and female) who have experienced sexual trauma in the military. The Department of Veterans Affairs is seeking to identify persons who may be eligible for services under this act.

While in the military:
Did you ever receive uninvited or unwanted sexual attention (e.g., touching or cornering, pressure for sexual favors, verbal remarks)? ☐ NO ☐ YES ☐ DECLINE TO ANSWER

While in the military:
Did you ever have an experience where someone used force or the threat of force to have sexual relations against your will"? ☐ NO ☐ YES ☐ DECLINE TO ANSWER

Are you currently bothered by feelings about any of these events?
☐ NO ☐ YES ☐ DECLINE TO ANSWER

Would you like to obtain counseling or further evaluation for this now?
☐ NO ☐ YES ☐ DECLINE TO ANSWER

AREAS OF STRENGTH / IMPROVEMENT

What would you consider to be your personal strengths?

_____

_____

What would you consider to be your personal areas which need improvement?

_____

_____

An **Advanced Care Directive for Mental Health** is a form in which you describe your preference regarding your mental health care should you ever be so ill that you are unable to make decisions for yourself. This includes things like preferred medications, side effects you'd like to avoid, ways that other people can help you feel comfortable, and lists of people who you would want contacted should you be in a psychiatric hospital, and those you do not wanted contact as well.

Would you like to be contacted about an Advanced Care Directive for Mental Health?
☐ NO ☐ YES

THANK YOU FOR COMPLETING THIS FORM