

**Georgia Department of Human Resources
MENTAL HEALTH QUESTIONNAIRE**

NAME: _____

DATE: _____

Please circle **Yes** or **No** for the following questions:

- | | | |
|---|-----|----|
| 1. Have you ever been in counseling/therapy for yourself and/or a family member? | Yes | No |
| a. If so, was the counseling or therapy helpful? | Yes | No |
| 2. Have you ever been evaluated or treated by a psychiatrist?
If yes, approximate date of last visit _____ | Yes | No |
| 3. Have you ever been a patient in a psychiatric hospital?
If yes, approximate date of last admission _____ | Yes | No |
| 4. Have you ever received outpatient substance abuse treatment?
If yes, approximate date of most recent treatment _____ | Yes | No |
| 5. Have you ever been a patient in a substance abuse day treatment program? If yes, approximate date of most recent discharge _____ | Yes | No |
| 6. Have you ever been a patient in a substance abuse inpatient program?
If yes, approximate date of most recent discharge _____ | Yes | No |
| 7. Have you ever suffered a serious head injury? | Yes | No |
| (a) Without loss of consciousness?
If yes, approximate age of injury _____ | Yes | No |
| (b) With loss of consciousness?
If yes, approximate age of injury _____ | Yes | No |
| 8. Please list all current medications, and indicate the purpose of the medications: | | |
