NAME:_____ DOB:_____

Mental Health Screening Form-III

Instructions: Read each question and circle the appropriate response. Please note, each item refers to your entire life history, not just your current situation. This is why each question begins with "Have you ever….."

1. Have you ever talked to a psychiatrist, psychologist, therapist, social worker, or counselor about an emotional problem?

   YES NO

2. Have you ever felt you needed help with your emotional problems, or have you had people tell you that you should get help for your emotional problems?

   YES NO

3. Have you ever been advised to take medication for anxiety, depression, and/or hearing voices or for any other emotional problem?

   YES NO

4. Have you ever been seen by mobile crisis or in an emergency room or been hospitalized for psychiatric reasons?

   YES NO

5. Have you ever heard voices no one else could hear or seen objects or things which others could not see?

   YES NO

6. Have you ever been depressed for weeks at a time, lost interest or pleasure in most activities, had trouble concentrating and making decisions, or thoughts about killing yourself?

   YES NO

7. Have you ever attempted to kill yourself?

   YES NO

8. Have you ever experienced any strong fears? For example, of heights, insects, animals, dirt, attending social events, being in a crowd, being alone, being in places where it may be hard to escape or get help?

   YES NO

9. Have you ever given into an aggressive urge or impulse, on more than one occasion that resulted in serious harm to others or led to the destruction of property? YES NO

10. Have you ever experienced any emotional problems associated with your sexual interests, your sexual activities, or your choice of sexual partner?

    YES NO

11. Have you ever felt that people had something against you, without them necessarily saying so, or that someone or some group may be trying to influence your thoughts or behaviors?

    YES NO

12. Have you ever had a period in your life when you spent a lot of time thinking and worrying about gaining weight, becoming fat, or controlling your eating? For example, by repeatedly dieting or fasting, engaging in much exercise to compensate for binge eating, taking enemas, or forcing yourself to throw up?

YES NO

13. Have you ever had spells or attacks when you suddenly felt anxious, frightened, uneasy to the extent that you began sweating, your heart began to beat rapidly, you were shaking or trembling, your stomach was upset, you felt dizzy or unsteady, as if you would faint?

YES NO

14. Have you ever had a period of time when you were so full of energy and your ideas came very rapidly, when you talked nearly non-stop, when you moved quickly from one activity to another, when you needed little sleep, and believed you could do almost anything?

YES NO

15. Have you ever had a persistent, lasting thought or impulse to do something over and over that caused you considerable distress and interfered with normal routines, work, or your social relations? For example repeatedly counting things, checking and rechecking on things you had done, washing and rewashing your hands, praying, or maintaining a very rigid schedule of daily activities from which you could not deviate?

YES NO

16. Have you ever lost considerable sums of money through gambling or had problems at work, in school, with your family and friends as a result of your gambling?

YES NO

17. Have you ever been told by teachers, guidance counselors, or others that you have a special learning problem?

YES NO

COMMENTS:_____

_____

_____

_____

Total Score of YES Responses:_____

If you have checked more than three YES remarks, it is suggested to contact a mental health provider.