

## Mental Health Screening Form–III (MHSF–III)

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**Instructions:** In this program, we help people with *all* their problems, not just their addictions. This commitment includes helping people with emotional problems. Our staff is ready to help you to deal with any emotional problems you may have, but we can do this only if we are aware of the problems. Any information you provide to us on this form will be kept in strict confidence. It will not be released to any outside person or agency *without your permission*. If you do not know how to answer these questions, ask the staff member giving you this form for guidance. Please note, each item refers to your *entire life history*, not just your current situation. This is why each question begins, “Have you ever . . .”

**Please circle “yes” or “no” for each question.**

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, hearing voices, or for any other emotional problem? ..... Yes No
4. Have you *ever* been seen in a psychiatric 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. (a) Have you *ever* been depressed for weeks at a time, lost interest or pleasure in most activities, had trouble concentrating and making decisions, or thought about killing yourself? ..... Yes No  
(b) Did you ever attempt to kill yourself? ..... Yes No
7. Have you *ever* had nightmares or flashbacks as a result of being involved in some traumatic/terrible event? For example, warfare, gang fights, fire, domestic violence, rape, incest, car accident, being shot or stabbed? ..... 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 in to 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* 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 behavior? ..... Yes No
11. Have you *ever* experienced any emotional problems associated with your sexual interests, your sexual activities, or your choice of sexual partner? ..... Yes No
12. Was there *ever* 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

*continued on other side*

- 13. 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 nonstop, when you moved quickly from one activity to another, when you needed little sleep, and when you believed you could do almost anything? .... Yes No
- 14. Have you ever had spells or attacks when you suddenly felt anxious, frightened, or uneasy to the extent that you began sweating, your heart began to beat rapidly, you were shaking or trembling, your stomach was upset, or you felt dizzy or unsteady, as if you would faint? ..... 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 social relations? Examples would include 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, or 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

Print client's name: \_\_\_\_\_

Program to which client will be assigned: \_\_\_\_\_

Name of admissions counselor: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewer's comments: \_\_\_\_\_

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