

Naval Hospital Rota, Spain
Behavioral Services Department

INSTRUCTIONS: Please provide all of the requested information below:

Are you here on a voluntary basis? Yes No (If no, or unsure, please see the Corpsman)	
NAME: _____ <small style="margin-left: 100px;">Last, First, MI</small>	SPONSOR SSN: _____
CURRENT ADDRESS: _____	
CURRENT PHONE: (home) _____ (work) _____ (cell) _____	
GENDER: male female	AGE: _____ D.O.B _____
ETHNICITY: _____	NATIONAL ORIGIN: _____
FOR DEPENDENT (only)	
Are you currently employed? Yes No	
If yes: Where: _____ Job title: _____ How long: _____	
FOR ACTIVE DUTY (only)	
SERVICE: USN USMC USCG USA USAF	RANK/RATE: _____
COMMAND: _____	Dept: _____
TIME AT PRESENT DUTY STATION: _____	DUTY PHONE: _____
TIME IN SERVICE: _____ yrs. _____ mos.	End of Service Date: _____
JOB IN SERVICE: _____ <small style="margin-left: 100px;">(your job title)</small>	Do you like your Job? Yes No Undecided
BACKGROUND INFORMATION	
Where did you grow up? _____ Are you adopted? Yes No	
# of brothers _____ sisters _____ Birth order 1 st 2 nd 3 rd 4 th 5 th 6 th 7 th 8 th 9 th 10 th _____	
Parent's Marital Status: Married Separated Divorced Widowed Never Married	
If appropriate, at what age were your parents separated, divorced or widowed? _____	
Who raised you (please be as specific as possible)? _____ <small style="margin-left: 100px;">(e.g. parents, aunts/uncles, brothers/sisters, grandparents, foster care, etc.)</small> _____ _____	
Did anyone else live with you while you were growing up? Yes No	
If "Yes," who? _____	
Please describe your home environment growing up: _____ _____	

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Have you ever _____?		If "Yes," please describe, please include your age at the time:
1. suffered a head injury with a loss of consciousness?	Yes No	_____
2. been diagnosed with or treated for attention deficit disorder or hyperactivity?	Yes No	_____
3. been diagnosed with a learning problem or disorder?	Yes No	_____
4. suffered from seizures?	Yes No	_____

Are you currently taking _____?		If "yes" please provide the type, dosage and how long you have been taking it:
1. any over the counter medications?	Yes No	_____
2. any prescription medications?	Yes No	_____
3. any dietary or body building supplements?	Yes No	_____
4. Are you allergic to any medications?	Yes No	_____

Do you drink alcohol?	Yes No	Have you ever used any illegal or illicit drugs?	Yes No
1. Have you ever tried to cut down on your drinking?	Yes No	Drugs used: _____	
2. Has anyone ever been angry with you about your drinking?	Yes No	_____	
3. Have you ever felt guilt about something you did while drinking?	Yes No	_____	
4. Have you ever had an "eye-opener" or "pick me up?" (a drink first thing in the morning to steady your nerves or relieve a "hangover")	Yes No	_____	
5. Have you ever had any legal problems related to alcohol use (DUI, PI, or MIP, etc.) or any alcohol related incidents?	Yes No	Do you use tobacco products?	
		Amount used: _____	

Average consumption (alcohol): _____		
Is there any history of alcohol or drug problems in your family?	Yes No	If so, What: _____ _____

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Are you in any legal (military/civilian) trouble now? Yes No			
List all office hours/NJP's or courts martial's (with date, UCMJ articles violated – titles, not numbers):			
List any civilian arrests:			
At what age did you _____?		Do you have a serious romantic involvement now, explain? _____	
1. begin dating _____		_____	
2. have your first serious/romantic relationship? _____		_____	
Your marital status: single, engaged, married, remarried, divorced, widowed		If married, for how long? _____ years	
How happy are you with your current marital or relationship status? _____			

Do you have any children?	Yes No	How many? _____	Ages: _____
Describe any concerns or problems you have in your current relationships:			

Growing up, discuss how you got along with your parents:			

Growing up, discuss how you got along with your brothers/sisters:			

Growing up, discuss how you got along with your peers:			

Were you ever fired from a job? Yes No
List the jobs you held prior to entering the service: _____

Do you belong to a church? Yes No What is your faith? _____ How often do you attend church? _____ Do you consider yourself religious? Yes No While growing up, was your family religious? Yes No Do you wish to speak to the chaplain? Yes No	Comments about your religious feelings? _____ _____ _____ _____ _____
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Please describe in as much detail as possible, the problems that bring you here? Use the back if necessary.

Has there been a change in your:		If yes, please describe:	If yes, length of time (days, weeks, months):
Mood	Yes No		
Appetite	Yes No		
Sleep	Yes No		
Sex drive	Yes No		
Energy Level	Yes No		
Concentration	Yes No		
Interest in enjoyable activities	Yes No		

Please check any of the items below that seem to apply or describe you over a **great portion** of your life (to the right provide any comments necessary for clarification):

- Difficulty trusting people
- Holding Grudges
- Few Close friends
- Unusual experiences
- Thinking or speech that others have thought was odd
- Behavior that others have thought odd or eccentric
- Impulsive
- Irritable
- Reckless
- Irresponsible
- Unstable or unhealthy relationships
- Unpredictable mood swings
- Feelings of emptiness
- Intense anger
- A strong need to be the center of attention
- Fears of criticism
- Feeling socially awkward or incompetent
- Difficulty making decisions
- Difficulty disagreeing with others
- Difficulty starting projects
- Uncomfortable alone
- Perfectionist
- Overly conscientious

1. Are you currently having thoughts of hurting yourself ? Yes___NO___
2. Are you currently having thought of hurting others? Yes___NO___
3. Any family history of Behavioral Health Services? Yes___NO___
4. Have you received treatment from Behavioral Health Service before? Yes___NO___

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Please list the biggest stressor(s) in you life now?

List anything else you would like to tell us (use the back if necessary).

Previous Psychiatric History:

<p>Have you received any previous psychiatric or mental health treatment?</p> <p>Why were you treated?</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Yes No</p>	<p>Name of Doctor and Place of treatment: _____</p> <p>_____</p> <p>Address: _____</p> <p>_____</p> <p>Phone Number: _____</p> <p>When: _____</p> <p>Were you prescribed any medication during this treatment? If so, what:</p> <p>_____</p> <p>_____</p>
<p>Is there any history of psychiatric illness in your immediate family? (mother, father, brother, sister)</p>	<p>Yes No</p>	<p>If so, What:</p> <p>_____</p> <p>_____</p>

Patient's Signature _____ Date: _____

BY SIGNING THIS FORM YOU AGREE THAT YOU HAVE READ AND UNDERSTAND ALL DOCUMENTATION ON THESE FORMS. YOU ALSO AGREE THAT TO THE BEST OF YOUR KNOWLEDGE, ALL PERSONAL ANSWERS AND STATEMENTS ON THESE FORMS ARE CORRECT AND TRUE.

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