Section 5 – Psychological and Emotional Health

The U.S. government recognizes the critical importance of mental health and advocates proactive management of mental health conditions to support the wellness and recovery of Federal employees and others. Every day individuals with mental health conditions carry out their duties without presenting a security risk. While most individuals with mental health conditions do not present security risks, there may be times when such a condition can affect a person's eligibility for a security clearance.

Individuals experience a range of reactions to traumatic events. For example, the death of a loved one, divorce, major injury, service in a military combat environment, sexual assault, domestic violence, or other difficult work-related, family, personal, or medical issues may lead to grief, depression, or other responses. The government recognizes that mental health counseling and treatment may provide important support for those who have experienced such events, as well as for those with other mental health conditions. Nothing in this questionnaire is intended to discourage those who might benefit from such treatment from seeking it.

Mental health treatment and counseling, in and of itself, **is not a reason** to revoke or deny eligibility for access to classified information or for holding a sensitive position, suitability or fitness to obtain or retain Federal or contract employment, or eligibility for physical or logical access to federally controlled facilities or information systems. Seeking or receiving mental health care for personal wellness and recovery may contribute favorably to decisions about your eligibility.

5A) Has a court or administrative agency **EVER** issued an order declaring you mentally incompetent?	YES	NO (Required to validate)

Branch If Yes to Being Declared Incompetent (Multiple Entries Allowed)

You responded 'Yes' to having a court or administrative agency **EVER** issuing an order declaring you mentally incompetent.		
Provide the date this occurred.	Date (Month/Year) (Estimated)	
Provide the name of the court or administrative agency that declared you mentally incompetent.	Name (Free Text)	
Provide the address of the court or administrative agency.		
Street address and city	State and Zip Code or Country	
Was this matter appealed to a higher court or administrative agency?	YES	NO (Required to validate)

Branch If Yes to Appealed to a Higher Court or Administrative Agency. (Multiple Entries Allowed)

You responded 'Yes' to appealed to a higher court or administrative agency.		
Provide the name of the court or administrative agency.	Name (Free Text)	
Provide the address of the court or administrative agency		
Street address and city	State and Zip Code or Country	
Provide the final disposition.	Disposition (Free Text)	

Do you have an additional instance where this matter was appealed to a higher court or administrative agency?	YES (Yes adds another entry)	NO (Required to validate)
Do you have an additional instance where a court or administrative agency EVER issued an order declaring you mentally incompetent?	YES (Yes adds another entry)	NO (Required to validate)

5B) Has a court or administrative agency EVER ordered you to consult with a mental health professional (for example, a psychiatrist, psychologist, licensed clinical social worker, etc.)? (An order to a military member by a superior officer is not within the scope of this question, and therefore would not require an affirmative response. An order by a military court would be within the scope of the question and would require an affirmative response.)	YES	NO (Required to validate)

Branch If Yes to Court or Administrative agency EVER ordered you to consult with a mental health professional (Multiple Entries Allowed)

You responded 'Yes' to having a court or administrative agency **EVER** ordered you to consult with a mental health professional.		
Provide the date this occurred.	Date (Month/Year) (Estimated)	
Provide the name of the court or administrative agency that declared you mentally incompetent.	Name (Free Text)	
Provide the address of the court or administrative agency.		
Street address and city	State and Zip Code or Country	
Provide the final disposition	Disposition (Free Text)	
Was this matter appealed to a higher court or administrative agency?	YES	NO (Required to validate)

Branch If Yes to Appealed to a Higher Court or Administrative Agency. (Multiple Entries Allowed)

You responded 'Yes' to appealed to a higher court or administrative agency.		
Provide the name of the court or administrative agency.	Name (Free Text)	
Provide the address of the court or administrative agency		
Street address and city	State and Zip Code or Country	
Provide the final disposition.	Disposition (Free Text)	

Do you have an additional instance where this matter was appealed to a higher court or administrative agency?	YES (Yes adds another entry)	NO (Required to validate)
Do you have an additional instance where a court or administrative agency EVER ordered you to consult with a mental health professional (for example, a psychiatrist, psychologist, licensed clinical social worker, etc.)? (An order to a military member by a superior officer is not within the scope of this question, and therefore would not require an affirmative response. An order by a military court would be within the scope of the question and would require an affirmative response.)	YES (Yes adds another entry)	NO (Required to validate)

5C) Have you EVER been hospitalized for a mental health condition?	YES	NO (Required to validate)

Branch If Yes to

You responded 'Yes' to EVER been hospitalized for a mental health condition.		
Was the admission voluntary or involuntary?	Voluntary (Provide explanation)	Explanation

EVER been hospitalized for a mental health condition (Multiple Entries Allowed)		Involuntary (Provide explanation)	Explanation
	Provide the dates of treatment.	From Date (Month/Year) (Estimated)	To Date (Month/Year) (Estimated/Present)
	Provide the name and address of the facility where treatment was provided.	Name (Free Text)	
	Provide the address of the facility where treatment was provided.		
	Street address and city	State and Zip Code or Country	
	Do you have an additional instance where you have EVER been hospitalized for a mental health condition?	YES (Yes adds another entry)	NO (Required to validate)

*The following question asks whether you have been diagnosed with a specified mental health condition that may, particularly if untreated, impact your judgment, reliability, or trustworthiness. If you answer in the affirmative, we will seek additional information about the seriousness and symptoms of the condition, as well as any applicable course of treatment. It is important to note that any such diagnosis, in and of itself, **is not a reason** to revoke or deny eligibility/or access to classified information or for holding a sensitive position, suitability or fitness to obtain or retain Federal or contract employment, or eligibility for physical or logical access to federally controlled facilities or information systems.*

5D) Have you EVER been diagnosed by a physician or other health professional (for example, a psychiatrist, psychologist, licensed clinical social worker, or nurse practitioner) with psychotic disorder, schizophrenia, schizoaffective disorder, delusional disorder, bipolar mood disorder, borderline personality disorder, or antisocial personality disorder?	YES	NO (Required to validate)

Branch If Yes to EVER been diagnosed by a physician or other health professional (Multiple Entries Allowed)	You responded 'Yes' to having EVER been diagnosed by a physician or other health professional.			
	Identify the diagnosis or health condition.	Diagnosis or health condition (Free Text)		
	Provide the dates of diagnosis.	From Date (Month/Year) (Estimated)	To Date (Month/Year) (Estimated/Present)	
	Provide the name, address, and telephone number of the health care professional who diagnosed you, or is currently treating you for such diagnosis, or with whom you have discussed such condition.	Name (Free Text)	Telephone Number (Free Text)	
	Provide the address of the health care professional who diagnosed you, or is currently treating you for such diagnosis, or with whom you have discussed such condition.	Street address and city	State and Zip Code or Country	
	Provide the name, address, and telephone number of any agency/organization/facility where counseling/treatment was provided	Name or same as above (Free Text)	Telephone Number or same as above (Free Text)	
	Provide the address of any agency/organization/facility where counseling/treatment was provided	Street address and city or same as above	State and Zip Code or Country or same as above	
	Was the counseling/treatment effective in managing your symptoms? Provide explanation.	YES	NO (Provide explanation) (Required to validate)	Explanation (Free Text)
	Do you have an additional instance where you EVER had been diagnosed by a physician or other health professional (for example, a psychiatrist, psychologist, licensed clinical social worker, or nurse practitioner) with psychotic disorder, schizophrenia, schizoaffective disorder, delusional disorder, bipolar mood disorder, borderline personality disorder, or antisocial personality disorder?	YES (Yes adds another entry)	NO (Required to validate)	
	In the last seven years, have there been any occasions when you did not consult with a medical professional before altering or discontinuing, or failing to start a prescribed course of treatment for any of the listed diagnoses?	YES	NO (Required to validate)	
Branch If Yes to currently in treatment. (Multiple Entries Allowed)	Are you currently in treatment?	YES	NO (Required to validate)	
	Provide the name, address, and telephone number of the healthcare professional providing such treatment.	Name (Free Text)	Telephone Number (Free Text)	
	Provide the address of the healthcare professional providing such treatment.	Street address and city	State and Zip Code or Country	
	Do you have an additional instance where you are currently in treatment?	YES (Yes adds another entry)	NO (Required to validate)	

5E) Do you have a mental health or other health condition that **substantially adversely** affects your judgment, reliability, or trustworthiness even if you are not experiencing such symptoms today? *Note: If your judgment, reliability, or trustworthiness is not substantially adversely affected by a mental health or other condition, then you should answer "no" even if you have a mental health or other condition requiring treatment. For example, if you are in need of emotional or mental health counseling as a result of service as a first responder, service in a military combat environment, having been sexually assaulted or a victim of domestic violence, or marital issues, but your judgment, reliability or trustworthiness is not substantially adversely affected, then answer "no."*	YES	NO (Required to validate)

Branch If Yes to having a mental health condition that adversely affects your judgment, reliability, or trustworthiness. (Multiple Entries Allowed)	You responded 'Yes' to having a mental health condition that substantially adversely affects your judgment, reliability, or trustworthiness.					
	Did you ever receive or are you currently receiving counseling or treatment for that condition? (You may choose not to answer this question. However, such consultation or treatment will not disqualify you and is considered to be a positive action.)	YES	NO (Provide explanation) (Required to validate)	Explanation (Free Text)	I decline to answer (Required to validate)	
	Branch If Yes to you ever received or are you currently receiving counseling or treatment for that condition. (Multiple Entries Allowed)	Provide the following about your counseling or treatment.				
		Provide the dates of counseling or treatment.	To Date (Month/Year) (Estimated)	To Date (Month/Year) (Estimated/Present)		
		Provide the name, address, and telephone number of the health care professional.	Name (Free Text)	Telephone Number (Free Text)		
		Provide the address of the health care professional.	Street address and city	State and Zip Code or Country		
		Provide the name, address, and telephone number of the agency/organization/facility where counseling/treatment was provided	Name or same as above (Free Text)	Telephone Number or same as above (Free Text)		
		Provide the address of the agency/organization/facility where counseling/treatment was provided	Street address and city or same as above	State and Zip Code or Country or same as above		
	Do you have an additional instance where you ever received or are you currently receiving counseling or treatment for that condition? (You may choose not to answer this question. However, such consultation or treatment will not disqualify you and is considered to be a positive action.)		YES (Yes adds another entry)	NO (Required to validate)	I decline to answer (Required to validate)	
	Have you ever chosen not to follow a prescribed course of treatment for any of these conditions?		YES	Explanation (Free Text)	NO (Required to validate)	