BLUEZONEHEALTHNH.COM
P: 603-880-4150
F: 603-880-6765

29 RIVERSIDE STREET
UNITS A & B
NASHUA, NH 03062

MISSION: TO RAISE THE VIBRATION OF EVERYONE WHO WALKS THROUGH OUR DOOR.
VISION: TO REVOLUTIOIZE HEALTHCARE IN OUR COMMUNITY.

Welcome to Mental Health!

This questionnaire is for the purpose of getting to you know you better in order to provide the best possible mental health services. Please complete this form as honestly and completely as possible. All information that you provide us will be confidential as required by state and federal law.

Today's Date:______________________ Social Security Number: ______________________

Name:______________________ Date of Birth:______________________ Age:__________

Any change in your personal information (i.e., address, phone number, marital status, etc.) from what we have?

☐ Yes, there is a change *(please provide this information)* ☐No Change

Partner's Name: ______________________ Age: __________ Occupation:______________________

If you have children, please list their names and ages below:

#	Name	Sex	Age	#	Name	Sex	Age
1				**4**			
2				**5**			
3				**6**			

Who currently lives in your residence? (adults and children):

#	Name	Relation	Sex	Age	#	Name	Relation	Sex	Age
1					**4**				
2					**5**				
3					**6**				

What made you come in at this time?____

____

____

____

How long has this been going on? ____

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What do you hope to gain from this evaluation and/or counseling?____

____

____

If you had difficulties in the past, what have you done to cope? Was it helpful? ____________________________

____

____

Symptoms:

Please **check** any symptoms or experiences that you have had **in the last month.**

☐ Difficulty falling asleep ☐ Difficulty staying asleep ☐ Difficulty getting out of bed
☐ Not feeling rested in the morning Average hours of sleep per night: ______________________________

☐ Persistent loss of interest in previously enjoyed activities ☐ Withdrawing from other people
☐ Spending increased time alone ☐ Depressed mood ☐ Feeling Numb
☐ Rapid mood changes ☐ Irritability ☐ Anxiety
☐ Panic Attacks ☐ Frequent feelings of guilt ☐ Difficulty leaving your home
☐ Avoiding people, places, activities, or specific things ☐ Outbursts of anger
☐ Repetitive behaviors or mental acts (i.e., counting, checking doors, washing hands)

☐ Worthlessness ☐ Hopelessness ☐ Sadness
☐ Feeling or acting like a different person ☐ Fear ☐ Helplessness

☐ Changes in appetite: ☐ Eating More ☐ Eating less
☐ Voluntary vomiting ☐Excessive exercise to avoid weight gain ☐ Use of laxatives
☐ Binge eating ☐ Are you trying to lose weight?_____________
☐ Weight gain: _______________lbs. ☐ Weight Loss: _______________lbs.

☐ Difficulty catching your breath ☐ Increase muscle tension ☐ Unusual sweating
☐ Easily started, feeling "jumpy" ☐ Increased energy ☐ Decreased energy
☐ Tremor ☐ Dizziness ☐ Frequent worry
☐ Physical sensations others don't have ☐ Racing thoughts ☐ Intrusive memories

☐ Difficulty concentrating ☐ Large gaps in memory ☐ Flashbacks
☐ Nightmares ☐ Thoughts of harming or killing yourself ☐ Thought about harming or killing others

☐ Feeling as if you were outside yourself, detached, observing what you are doing
☐ Feeling puzzled as to what is real and unreal
☐ Persistent, repetitive, intrusive thoughts, impulses, or images
☐ Unusual visual experiences such as flashes of light, shadows
☐ Hear voices when no one else is present
☐ Feeling that your thoughts are controlled or placed in your mind
☐ Feeling that the television or the radio is communicating with you
☐ Difficulty problem solving ☐ Difficulty meeting role expectations ☐ Dependency on others
☐ Manipulation of others to fulfill your own desires ☐ Inappropriate expression of anger
☐ Self-mutilation/cutting ☐ Difficulty or inability to say "no" to others
☐ Sense of lack of control ☐ Decreased ability to handle stress ☐ Abusive relationship
☐ Difficulty expressing emotions ☐ Concerns about your sexuality ☐ Ineffective communication

Sexual orientation: ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ I choose not to answer ☐ Other_________

Please describe any other symptoms or experiences you have had problems with: ______________________________
____
____
____
____

Have you seen a counselor, psychologist, psychiatrist, or other mental health professional before?
☐ No ☐ Yes If so:

Name of provider:______________________________ Dates of treatment
Reason for seeking help:__________________________ ______________________________

Name of provider:______________________________ Dates of treatment
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Name of provider:______________________________ Dates of treatment
Reason for seeking help:__________________________ ______________________________

Are you **currently** taking **psychiatric** medication? ☐ No ☐ Yes If yes, please list:

Medication	Dosage	How long have you been taking it?	Has it been helpful?

Are you **currently** taking **non-psychiatric** medication? ☐ No ☐ Yes If yes, please list:

Medication	Dosage	How long have you been taking it?

Have you been on **psychiatric** medication in the past? ☐ No ☐ Yes If yes, please list:

Medication	Dosage	First/Last time you took it	Effect of Medication

Have you been hospitalized for psychiatric reasons? ☐ No ☐ Yes If yes, describe:

Hospital	Dates	Reason

FAMILY HISTORY

Father: Age:____________ ☐ Living ☐ Deceased Cause of death:______________________
If deceased, HIS age at time of his death:_____________ YOUR age at time of his death:______________________
Occupation:____ Health:____
Frequency of contact with him:______________________ Are you/Have you been close to him?_______________

Mother: Age:____________ ☐ Living ☐ Deceased Cause of death:______________________
If deceased, HER age at time of her death:_____________ YOUR age at time of her death:______________________
Occupation:____ Health:____
Frequency of contact with her:______________________ Are you/Have you been close to her?_______________

Brothers and Sisters:

Name	**Sex**	**Age**	**Whereabouts**	**Are you close to him/her?**			
					No		**Yes**
					No		**Yes**
					No		**Yes**
					No		**Yes**

Please place a check mark in the appropriate box if these are or have been present in your relatives:

	Children	Brothers	Sisters	Father	Mother	Uncle/Aunt	Grandparents
Nervous Problems							
Depression							
Hyperactivity							
Counseling							
Psychiatric Medication							
Psychiatric Hospitalization							
Suicide Attempt							
Death by Suicide							
Drinking Problem							

During your childhood, did you live any significant period of time with anyone other than your natural parents?
☐ No ☐ Yes If so, please give the person's name and relationship to you:

Name:______________________________ Relationship to you:____________________

SOCIAL HISTORY

Past Marital History
Have you been married previously?__________ If yes, please describe:

When?________ How long?__________ When?__________ How Long?________

Education
Highest grade level completed: __________ Degree obtained, if applicable: ________________
Did you have any disciplinary problems in school? If yes, please explain:____________________
Were you considered hyperactive/ADHD in school? ______________________________
If yes, were/are you on any medication?________________
If so, which medication?______________________
What kind of grades did you get in school?__________________________

Have you served in the military?______ If yes, please describe briefly:____________________
What type of discharge (separation) did you get?______________________________

Employment:
Are you currently employed?______ If yes, employer's name:______________________
What type of work do you do?____________________________________

Employment history (most recent first):

Type of Job	Dates	Reason of Leaving

Have you been arrested?: ________________ If yes, please describe:____

Do you have a religious affiliation?________ If yes, what is it?____

What kind of social activities do you participate in?____

Who do you turn to for help with your problems?____

Have you ever been abused?

☐ Verbally ☐ Emotionally ☐ Physically ☐ Sexually ☐ Neglected

Please describe:____

____

SUBSTANCE ABUSE

Please indicate for each drug listed below

Drug	**Ever used?**	**Age at 1st use**	**Tine since last use**	**Approx use in last 30 days**
Marijuana				
Cocaine				
Crack				
Heroin				
Methamphetamine				
Ecstasy				

Is there anything else you would like us to know about you?

Patient Signature:____ Date:________________________