



MENTAL HEALTH QUESTIONNAIRE

First Name: _____ Surname: _____

Address _____

Postcode: _____ Telephone: _____

e-Mail: _____

GP's name: _____

I heard about your services from: _____

Date of Birth (DOB): _____

Weight: _____ Height: _____

Have you ever been diagnosed with a Mental Health Problem? Y/N. If so:

what was diagnosis?	time period of symptoms? (e.g. 1987-88)	list medication given? If any.

Consultant Psychiatrist's, Psychologist's or Counsellor's Name (if currently seeing): _____

Out-Patient Hospital Name: _____

QUESTIONNAIRE NCQ001

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Describe your symptoms when not taking medication:

Describe how symptoms improve when taking medication:

Rate your Medication's effectiveness by ticking: Very; Mildly; Not effective

What makes you better?

What makes you worse?

FAMILY MENTAL HEALTH PROFILE

Family Member (e.g. father)	Name Mental Health Condition or Diagnosis



SYMPTOM PROFILE

a.) Please circle any symptoms below that you suffer from frequently or always ...

b.) Please underline any symptoms below that you suffer from often ...

c.) Please tick any symptoms below that you suffer from occasionally ...

- | | |
|---|---|
| <input type="checkbox"/> Nausea or Constipation | <input type="checkbox"/> Ideas of Grandeur |
| <input type="checkbox"/> Anxiety, Extreme Fears or Paranoia | <input type="checkbox"/> White Spots on Fingernails |
| <input type="checkbox"/> Feeling "Unreal" | <input type="checkbox"/> Phobias |
| <input type="checkbox"/> Pale Skin Which Burns Easily | <input type="checkbox"/> Hearing your own thoughts |
| <input type="checkbox"/> Poor concentration or confusion | <input type="checkbox"/> Frequent Colds and Infections |
| <input type="checkbox"/> Anxiety and Inner Tension | <input type="checkbox"/> Poor Memory |
| <input type="checkbox"/> Stretch | <input type="checkbox"/> Inability to think straight |
| <input type="checkbox"/> Angry or Aggressive Feelings | <input type="checkbox"/> Irregular Menstruation |
| <input type="checkbox"/> Learning difficulties or dyslexia | <input type="checkbox"/> Hyperactivity |
| <input type="checkbox"/> Impotency | <input type="checkbox"/> Suspicious of people |
| <input type="checkbox"/> Emotional ups and downs | <input type="checkbox"/> Crowded Upper Front Teeth |
| <input type="checkbox"/> Good pain tolerance | <input type="checkbox"/> Headaches and Migraines |
| <input type="checkbox"/> Poor Alcohol or Drug Tolerance | <input type="checkbox"/> Seeing or hearing things abnormally |
| <input type="checkbox"/> Sneezing in sunlight | <input type="checkbox"/> Poor Dream Recall |
| <input type="checkbox"/> Having delusions or illusions | <input type="checkbox"/> Crying, Salivating or feeling nauseous |
| <input type="checkbox"/> Dry Mouth | <input type="checkbox"/> Loose Bowels or skin problems at
onset of illness |
| <input type="checkbox"/> Easy Orgasm with Sex | <input type="checkbox"/> Poor Memory or Forgetfulness |
| <input type="checkbox"/> Difficult Orgasm with Sex | <input type="checkbox"/> Abnormal Fears, Compulsions, Rituals |
| <input type="checkbox"/> Mental Exhaustion | <input type="checkbox"/> Tendency to be Overweight |
| <input type="checkbox"/> Light Sleeper | <input type="checkbox"/> Difficulty Concentrating |
| <input type="checkbox"/> Frequent Mood Swings | <input type="checkbox"/> Fast Metabolism |
| <input type="checkbox"/> Palpitations or Blackouts | <input type="checkbox"/> Forgetfulness or Confusion |
| <input type="checkbox"/> Depression or suicidal thoughts | <input type="checkbox"/> Fainting, Dizziness or Trembling |
| <input type="checkbox"/> Tendency to Depression | <input type="checkbox"/> producing a lot of body heat |

