Generations
GERIATRIC MENTAL HEALTH

Location:
138 Webster Street
Manchester, NH

Mailing Address:
PO Box 3300
Manchester, NH 03105

Welcome to our practice:

Please fill out the information requested on these forms and bring them along with you on _____ at _____ a.m./p.m. Also, please bring all your medications and insurance cards. We are located in the Elliot Senior Health Center, at 138 Webster Street, Manchester, NH. We look forward to our meeting together. Thank You.

Name: _____ **Gender:** ☐ Male ☐ Female
Address: _____ **Marital Status:** ☐ Married
_____ ☐ Widowed
_____ ☐ Single
☐ Divorced

Phones: (Home) _____ **(Cell)** _____
Age:_____ **Date of Birth:** _____ **Birthplace:** _____
Race: ☐ Caucasian ☐ African American ☐ Hispanic ☐ Others ___
Religion: ☐ Catholic ☐ Protestant ☐ Jewish ☐ Other_____
Occupation (present or past):_____ **Education:**_____

Name of Spouse: _____ **Age of Spouse:** _____
Other person(s) residing with you: _____
Contact Person for appointments or emergency: _____
Relationship:_____ **Phone(s):** _____
Address: _____

Do you have a Durable Power of Attorney for Health Care? ☐Yes ☐No
Please bring it along with you. Thank you.
Name of Family Physician: _____ **Phone:** _____
Address: _____
Other Physicians you have: _____
_____
Referring Person: _____

Social Security Number: ___ ___ ___ - ___ ___ - ___ ___ ___ ___
Medicare Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___
Prescription Insurance: _____
Other Insurance: _____

PLEASE CALL IF YOU CANNOT KEEP THIS APPOINTMENT
PHONE # 603-645-5977
THANK YOU.

preserve • protect • restore

PRINCIPAL REASON FOR THIS VISIT: (Check all that apply)

❑ Memory Problems ❑ Depression ❑ Anxiety ❑ Mood Changes ❑ Confusion
❑ Fears ❑ Hallucinations

OTHER: _____

How long ago above symptoms first started: _____

Describe symptoms since beginning to the present time: _____

(If more space needed then write on back of this page)

Did you receive any treatment for this? What benefit from the treatment?

ANY PSYCHIATRIC HISTORY:

Year	Problems	MD/Therapist/Hospital	Type of Treatment	Outcome

CURRENT MEDICAL PROBLEMS:

CURRENT MEDICATIONS:

ALLERGIES:

Continues.....

ASSISTIVE DEVICES USED:

- ❑ Glasses
- ❑ Hearing Aids
- ❑ Cane
- ❑ Walker
- ❑ Wheelchair
- ❑ Scooter
- ❑ Others _____

DO YOU NEED ASSISTANCE WITH ANY OF THESE:

TASK	DON'T NEED HELP	NEED HELP	IF YOU NEED HELP, WHO HELPS? (Name and Relationship)
Feeding yourself			
Getting from bed to chair			
Getting to the toilet			
Getting dressed			
Bathing			
Using the telephone			
Taking your medicines			
Preparing meals			
Managing money/financial affairs/checkbook			
Doing laundry			
Doing house work			
Shopping for groceries			
Driving			
Doing 'handyman' work			
Climbing a flight of stairs			
Getting to places beyond walking distance			

(If more space needed, write on the back of this page)

Continues....

LEISURE ACTIVITIES: (Check if done regularly):

- ❑ Exercise
- ❑ Read
- ❑ Knit or crochet
- ❑ Other hobbies
- ❑ Converse on telephone
- ❑ Go to clubs or gatherings
- ❑ Do puzzles
- ❑ Watch TV
- ❑ Visit family
- ❑ See family
- ❑ Do crosswords
- ❑ Listen to music
- ❑ Visit friends
- ❑ Take care of others
- ❑ Play cards or games
- ❑ Sewing
- ❑ Baking
- ❑ Volunteer

RECENT SIGNIFICANT LIFE EVENTS (Check if occurred in past 2 years):

- ❑ Marriage
- ❑ Death of spouse
- ❑ Breakup of relationship
- ❑ Personal Injury or illness
- ❑ Retirement or loss of job
- ❑ Legal Difficulties
- ❑ Child in crisis
- ❑ Separation
- ❑ Child left home
- ❑ Marital Conflict
- ❑ Sexual difficulties
- ❑ New residence
- ❑ Loss of driving
- ❑ Divorce
- ❑ Serious argument with loved ones
- ❑ Conflict with family/Friend
- ❑ Problems at work
- ❑ Financial difficulties
- ❑ Bad health of family member/s

_____

_____

_____

DO YOU SMOKE? ❑ Yes ❑ No Packs per day:_____

CAFFEINE: ❑ None Cups per day ____Coffee ____Tea ____Soda

ALCOHOL USAGE:

What do you drink?

Most consumed in a 24 hour period during the last year:

Drinks per day:

Ever been told or felt you should cut down on drinking?	❑ Yes	❑ No
Ever felt bad or guilty about your drinking?	❑ Yes	❑ No
Ever drink first thing in the morning to get your nerves right?	❑ Yes	❑ No

SLEEP HABITS:

USUAL SLEEP TIMES Go to bed _____ Fall asleep_____ Wake up_____

SLEEP DIFFICULTIES (Please check any current problems)

- ❑ Difficulty falling asleep
- ❑ Waking up during the night
- ❑ Falling back to sleep
- ❑ Tired upon waking
- ❑ Nightmares
- ❑ Bad dreams
- ❑ Excessive daytime sleeping
- ❑ Snoring

Comments:

ANY SIGNIFICANT RECENTCHANGE IN YOUR MEDICAL CONDITION?

Continues....

MEDICAL HISTORY (continued)

Hospitalizations for Medical Problems (Include surgery):

Year	Place	Reason	Length of Stay	Outcome

Is there anything else you would like to tell us?

PLEASE HAVE A FAMILY MEMBER OR A FRIEND COMPLETE THE SECTION BELOW:
Name of the person filling this section: Relationship:
What are your concerns about patient's physical or mental health?

What should be the main focus for visit with us?

How would you describe patient's personality?

What are patient's main strengths?

Any other comments do you have?

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