COMMUNITY MENTAL HEALTH & PSYCHIATRY MEDICAL HISTORY QUESTIONNAIRE FOR VOLUNTARY ADMISSION TO A MENTAL HEALTH FACILITY

Name: _____ Date of Birth: _____

Date: _____ Identity no: _____

This brief questionnaire is about your health. It will assist us in determining your ability to participate in our program / services. This information is confidential.

Section 1

* **To be filled in by General Medical Practitioner or Professional Nursing Sister**

1. Name and Surname of Medical Practitioner / Professional Nursing Sister: (Please print)

_____

2. Name of Practice / Clinic / Institution:

_____

3. Tel no: Fax no: Cell no: Email:

_____

Questionnaire (To be addressed to the Applicant)

1. Do you have any serious health problems or illnesses (such as tuberculosis or active pneumonia) that may be contagious to others around you? If yes, please give details.
   No ☐ Yes ☐ Date: _____
2. Have you ever had a stroke? If yes, please give details.
   No ☐ Yes ☐ Date: _____
3. Have you ever had a head injury that resulted in a period of loss of consciousness? If yes, please give details.
   No ☐ Yes ☐ Date: _____
4. Have you ever had any form of seizures, delirium tremens or convulsions? If yes, please give details.
   No ☐ Yes ☐ Date: _____
5. Have you experienced or suffered any chest pains? If yes, please give details.
   No ☐ Yes ☐ Date: _____
6. Have you ever had a heart attack or any problem associated with the heart? If yes, please Give details.
   No ☐ Yes ☐ Date: _____
7. Do you take any medications for a heart condition? If yes, please give details.
   No ☐ Yes ☐ Date: _____
8. Have you ever had high-blood pressure or hypertension? If yes, please give details.
   No ☐ Yes ☐ Date: _____
9. Do you have a history of cancer? If yes, please give details.
   No ☐ Yes ☐ _____

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10. Do you have any allergies to medications, foods, animals, chemicals, or any other substance? If yes, please give details.
    No ☐ Yes ☐

11. Have you ever been diagnosed with diabetes? If yes, please give details, including insulin, oral medications, or special diet.
    No ☐ Yes ☐ Date:

12. Do you currently have any lung diseases such as asthma, emphysema, or chronic bronchitis? If yes, please give details.
    No ☐ Yes ☐

13. Please describe any surgeries or hospitalisations due to illness or injury that you have had.
    Date:

14. Do you take prescription medications for any physical conditions? If yes, please list type(s) and dosage(s).
    No ☐ Yes ☐

15. Do you have a history of any other illness that may require frequent medical attention? If yes, please give details.
    No ☐ Yes ☐

16. When was your last dental exam?
    Date:

17. Do you take any contraceptive medication? Please give details and date of last injection.
    No ☐ Yes ☐

18. Is there any other information regarding your physical health that you need to bring to our attention?
    No ☐ Yes ☐

19. I, _____ declare that the above information is true and correct to the best of my knowledge. I declare that a copy of all relevant prescriptions is attached to this Questionnaire

Signature: Date:

Section 2

*** To be filled in <u>ONLY</u> by a Psychiatrist or Professional Psychiatric Nursing Sister**

1. Name and Surname of Psychiatrist / Professional ***Psychiatric*** Nursing Sister: (Please print)

2. Name of Practice / Clinic / Institution:

3. Tel no: Fax no: Cell no: Email:

Questionnaire

1. Psychiatric Diagnosis: DSM IV/R Classification:
   Axis I

   Axis II

   Axis III

   Axis IV

   Axis V

2. Date of first diagnoses:

3. Approximately how many admissions did the Applicant have to a psychiatric hospital?

4. Date and length of latest admission?

5. At what hospital did the Applicant receive In patient treatment?
   File no: Tel no:

6. At what last hospital / clinic did the Applicant receive Out patient treatment?
   File no: Tel no:

7. Medication and dosage:

8. Name of Psychiatrist / Psychiatric Nursing sister acquainted with the Applicant:

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9. Does the Applicant have a history of, or incidents of violence or aggression? If yes, please give details.
   No ☐ Yes ☐

10. Does the Applicant have a history of substance abuse? If yes, please give details.
   No ☐ Yes ☐

11. Has the Applicant ever experienced suicidal ideations in the past or made suicidal attempts? If yes, please give details.
   No ☐ Yes ☐

12. Does the Applicant have sexual preoccupation or any sexual issues which have been identified? If yes, please give details.
   No ☐ Yes ☐

13. Does the Applicant have a gender identity disorder which has been identified? If yes, please give details.
   No ☐ Yes ☐

14. Was the Applicant admitted voluntary or compulsory to the psychiatric hospital?
   No ☐ Yes ☐

15. Is there a history or incidents of the Applicant missing or stopping treatment?
   No ☐ Yes ☐

16. Describe mood swings e.g. extremes of "highs" or "lows".

17. Describe any problems with disorientation / memory loss / other.

18. List and describe any other psychiatric / medical information not listed in this questionnaire, e.g. sleeplessness, etc. Describe any other problems that may warrant our attention:

19. I, _____ declare that the above information is true and correct to the best of my knowledge. I declare that a copy of all relevant prescriptions is attached to this Questionnaire.

Signature: Date:

For Office use:

I, _____ (name of CMHP Nursing Sister) declare that I have received this Questionnaire on the _____, and handed the original to the Director of Medical & Mental Health CMHP.

Signature: Date:

sassa

LIFE CERTIFICATE

I, the undersigned (full name and identity number/ date of birth)

_____

_____

residing at:

_____

_____

do hereby make oath and state that:

1. I am currently receiving a social grant in accordance with the Social Assistance Act, 2004 (Act No.13 of 2004) and its Regulation; and
2. In accordance with the Regulations to the Social Assistance Act, 2004 (Act No.13 of 2004), I hereby confirm that I am alive.

The particulars furnished on this form are to the best of my knowledge and belief, true and correct. I am aware that any false declaration is punishable by law.

_____

SIGNATURE/ THUMBPRINT OF DEPONENT

The above statement was explained to the beneficiary and he/she is satisfied with the contents thereof

Thus signed and sworn to on this day the ..... day of ..... .20.... the Deponent having acknowledged that he / she knows and understands the contents of this affidavit, has no objections to taking the oath / affirm the affidavit / having sworn / confirmed the contents thereof are true and correct and that he / she considers the oath / declaration to be binding on his / her conscience.

STAMP OF OFFICE

_____

NAME IN BLOCK LETTERS

_____

SIGNATURE: COMMISSIONER OF OATHS / DESIGNATED SASSA OFFICIAL/ OFFICIAL AT INSTITUTION

DATE: