OFFICE USE - Name:	DOB:	MRN:

WMHP INTAKE - POSTPARTUM

Thank you for taking time to complete this form. The information collected will help us to offer guidance as you make decisions regarding your care and will be kept strictly confidential.

NAME: ______________________________ **DATE:** ____/____/____ **AGE:** ________

ADDRESS: ______________________________

PHONE - HOME: ____________________ **CELL:** ____________________ **WORK:** ______________________

EMAIL: ________________________________ **SSN:** ________________________________

General Information

- **MARITAL STATUS**
  - Never married / living alone
  - Never married / living with partner
  - Married – How long? _____ How many times? _____
  - Divorced
  - Widowed

- **GENDER OF YOUR SPOUSE/PARTNER**
  - Male
  - Female

- **YOUR BIRTH DATE**____/____/____

- **PARTNER'S BIRTH DATE**____/____/_____

- **RACIAL BACKGROUND**
  - African American / African / Black
  - Asian / Indian
  - Caucasian
  - Native American / Alaska Native
  - Pacific Islander
  - More than one race
  - Other______________________

- **PARTNER'S RACIAL BACKGROUND**
  - African American / African / Black
  - Asian / Indian
  - Caucasian
  - Native American / Alaska Native
  - Pacific Islander
  - More than one race
  - Other______________________

- **ETHNICITY**
  - Hispanic Not Hispanic

- **PARTNER'S ETHNICITY**
  - Hispanic Not Hispanic

- **YOUR EDUCATION**
  - Did not finish high school
  - High school graduate/GED
  - Completed trade school
  - Some college
  - Associates Degree
  - Bachelor's degree
  - Some graduate school
  - Masters degree
  - Doctoral degree (PhD, MD, JD, EdD, etc)

- **PARTNER'S EDUCATION**
  - Did not finish high school
  - High school graduate/GED
  - Completed trade school
  - Some college
  - Associates Degree
  - Bachelor's degree
  - Some graduate school
  - Masters degree
  - Doctoral degree (PhD, MD, JD, EdD, etc)

- **YOUR OCCUPATION**

  ____

- **PARTNER'S OCCUPATION**

  ____

OFFICE USE - Name:	DOB:	MRN:

- **DURING THE LAST MONTH, WHAT WAS YOUR LEVEL OF FUNCTION AT WORK?**

Working full-time at a job
Working full-time running household
Working part-time
School/college full-time
School/college part-time
Doing volunteer work
Unemployed but able to work
Unable to work
Other ___________________

- **YOUR CURRENT LIVING SITUATION**

Living with your husband
Living with your partner / significant other
Living as a single parent with your child(ren)
Living on your own (alone or with roommate)
Living with your family of origin (parents, etc)
Living in a group home
Homeless
Other (describe) ____________________

Medical History

- **CURRENT WEIGHT** (lbs) _______________
- **YOUR PRE-PREGNANCY WEIGHT** (lbs) _____
- **YOUR HEIGHT** (ft., in.) __________
- **DO YOU HAVE ANY MEDICATION ALLERGIES?** YES NO

Medication: __________________________ Reaction: ____
Medication: __________________________ Reaction: ____
Medication: __________________________ Reaction: ____

- **PAST OR CURRENT MEDICAL PROBLEMS**

Autoimmune
Lupus
Multiple Sclerosis
Rhematoid Arthritis
Sjogren's Syndrome

Cardiovascular
Anemia (chronic)
Heart Disease
Hypertension
Phlebitis

Endocrine
Diabetes
Thyroid Disease

Gastrointestinal
Crohn's
GERD/Reflux
Irritable Bowel
Ulcerative Colitis

OB/GYN
Abnormal Pap
Endometriosis
Preeclampsia/HELLP
PCOS
Pelvic Inflamm.
PMS
Rh Disease

Infection
Chicken Pox
Group B Strep
Hepatitis
Herpes
HIV/AIDS
Tuberculosis
UTI (chronic)

Neurological
Epilepsy/Seizures
Migraines

Other
Asthma
Cancer
Kidney Disease
Other __________

Genetic History

Genetic Illness	Family History	Your Genetic Test Results
Cystic Fibrosis	YES NO	Normal Abnormal NOT TESTED
Down Syndrome	YES NO	Normal Abnormal NOT TESTED
Hemophilia	YES NO	Normal Abnormal NOT TESTED
Huntington's Disease	YES NO	Normal Abnormal NOT TESTED
Muscular Dystrophy	YES NO	Normal Abnormal NOT TESTED
Neural Tube Defect (spina bifida)	YES NO	Normal Abnormal NOT TESTED
Sickle Cell Disease	YES NO	Normal Abnormal NOT TESTED
Tay Sachs	YES NO	Normal Abnormal NOT TESTED
Thalassemia, Alpha	YES NO	Normal Abnormal NOT TESTED
Thalassemia, Beta	YES NO	Normal Abnormal NOT TESTED
OTHER (______________________________)	YES NO	Normal Abnormal NOT TESTED

OFFICE USE - Name:	DOB:	MRN:

Gynecological History

- **YOUR OB NAME / GROUP PRACTICE / ADDRESS / PHONE**

____

____

____

____

- **HOW OLD WERE YOU WHEN YOU HAD YOUR FIRST MENSTRUAL PERIOD?** ________________

- **HOW MUCH PAIN DO YOU USUALLY HAVE WITH YOUR PERIODS?**
  No Pain
  Mild cramps or infrequent pain (seldom needs meds)
  Moderate cramps, medication usually needed
  Severe cramps, medication and bed rest needed

- **HOW REGULAR IS YOUR MENSTRUAL CYCLE?**
  Regular _____ (number of days per cycle)
  Irregular

- **HAVE YOUR PERIODS EVER STOPPED TEMPORARILY?** YES NO
  If yes, mark which event caused your periods to stop and how long:
  Sudden weight loss
  Low body fat
  Chemotherapy or radiation treatment
  Hormonal Medication [Lupron (Leuprolide), Danocrine (Danzol), Synarel (Nafareline), Depo-provera]
  Unexplained
  Other ________________________

- **ARE YOU CURRENTLY USING BIRTH CONTROL?** YES NO
  If yes, please indicate the method of birth control ____________________________

Obstetrical History

- **HOW MANY TIMES HAVE YOU BEEN PREGNANT?** (including recent pregnancy) . . . . _____
- **HOW MAY FULL-TERM DELIVERIES?** (≥ 37 completed weeks) . . . . _____
- **HOW MANY PRETERM DELIVERIES?** (≥ 20 TO < 37 completed weeks) . . . . _____
- **HOW MANY MISCARRIAGES?** (pregnancy loss before 20 completed weeks) . . . . _____
- **HOW MANY ABORTIONS HAVE YOU HAD?** . . . . _____
- **HOW MANY LIVING CHILDREN DO YOU HAVE?** . . . . _____
  If one of your children has died, please explain the circumstances:

  ____

- **HOW MANY MULTIPLE GESTATIONS AND BIRTHS HAVE YOU HAD?** . . . . _____

PAST PREGNANCIES
Please include pregnancies that ended with miscarriage, stillbirth, tubal pregnancy, etc.

Date of Birth	Name of Child	Gender	Weeks	Wt	Length	Delivery Type	Anesthesia	Pregnancy/Delivery Complications

Delivery Type: Vaginal, C/S, Forceps, Vacuum **Anesthesia:** Epidural, Local, General, Demerol **Complications:** Diabetes, Bleeding, Hypertension

Recent Pregnancy

- **WAS THIS PREGNANCY PLANNED?** YES NO
- **WAS THIS PREGNANCY DESIRED?** YES NO MIXED FEELINGS
- **METHOD OF CONCEPTION**
  - Natural — Fertility Drug(s) ______________________________
  - IUI — IVF
  - ICSI — GIFT — ZIFT
  - Did you use donor eggs? Yes No
  - Did you use donor sperm? Yes No
- **WHEN WAS YOUR ESTIMATED DATE OF DELIVERY?** _____/_____/_____

- **LIST ALL MEDICATIONS, VITAMINS, HERBS & SUBSTANCES TAKEN DURING PREGNANCY**

Name	Usual Daily Dose	Frequency	What weeks?
Caffeine			
Tobacco			
Alcohol			

- **WHICH OF THE FOLLOWING COMPLICATIONS DID YOU HAVE IN THIS PREGNANCY?**

Nausea (mild)
Nausea (severe)
Headaches (tension)
Headaches (migraine)
Gestational diabetes
Oligohydramnios (low fluid)
Polyhydramnios (high fluid)
UTI
Placenta previa
Preterm labor
PIH (hypertension)
Restless Legs Syndrome
Preeclampsia
Eclampsia (toxemia)
HELLP Syndrome

OFFICE USE - Name:	DOB:	MRN:

Postpartum

- **DATE OF DELIVERY** ______/______/______

- **DID YOU OR YOUR BABY HAVE ANY COMPLICATIONS AT DELIVERY?**

____

____

____

____

____

____

- **WHAT METHODS ARE YOU USING TO FEED YOUR BABY?**

Bottle/Formula   Breastfeeding
Both   Other: _______________

- **HAVE YOU OR DID YOU HAVE DIFFICULTIES WITH BREASTFEEDING?**

____

____

- **HAS YOUR MENSTRUAL CYCLE RETURNED?** YES NO

- **WHAT METHOD OF BIRTH CONTROL ARE YOU USING?**

____

____

- **PEDIATRICIAN'S NAME / GROUP PRACTICE / ADDRESS:**

____

____

____

- **DOES YOUR BABY HAVE ANY HEALTH CONCERNS?**

____

____

____

OFFICE USE - Name:	DOB:	MRN:

Psychiatric History

- **HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING DISORDERS?**

Mood Disorders	**Psychotic Disorders**
Major Depression	Schizophrenia
Postpartum Depression	Schizoaffective Disorder
Dysthymic Disorder	Any Other Psychotic Disorder
PMS / Premenstrual Depression	**Eating Disorders**
Bipolar Disorder / Manic Depression	Anorexia Nervosa
Anxiety Disorders	Bulimia Nervosa
Generalized Anxiety Disorder	Any Other Eating Disorder
Panic Disorder	**Substance Use Disorders**
Obsessive Compulsive Disorder	Alcohol Abuse or Dependence
Social Anxiety Disorder	Cocaine Abuse or Dependence
Posttraumatic Stress Disorder	Opiate Abuse or Dependence
Any Other Anxiety Disorder	Any Other Substance Abuse Disorder
Personality Disorders	**Other Disorders**
Antisocial Personality Disorder	Attention Deficit Hyperactivity Disorder
Borderline Personality Disorder	Migraine Headaches
Any Other Personality Disorder	Seizure Disorder / Epilepsy
	Other, Please Specify _______________________

- **YOUR CURRENT PSYCHIATRIST'S NAME / ADDRESS / PHONE**

____

____

- **YOUR CURRENT PSYCHOTHERAPIST'S/COUNSELOR'S NAME / ADDRESS / PHONE**

____

____

- **PREVIOUS SUICIDE ATTEMPTS?** LIST NUMBER OF TIMES, METHODS, DATES:

____

____

- **PREVIOUS SELF-INJURY (E.G. CUTTING)?** LIST NUMBER OF TIMES, DATES:

____

____

- **PREVIOUS HOMICIDE OR VIOLENCE (INCLUDING CHILDREN)?**

____

- **PREVIOUS PSYCHIATRIC HOSPITALIZATIONS? WHERE AND WHEN?**

____

____

____

- **WHAT TYPES OF PSYCHOTHERAPY HAVE YOU PREVIOUSLY HAD?**

CBT (Cognitive Behavioral Therapy) Couples Therapy Psychodynamic Therapy
DBT (Dialectial Behavior Therapy) Family Therapy Supportive Therapy
Other ________________________________

OFFICE USE - Name:	DOB:	MRN:

◆ **WHAT PSYCHIATRIC MEDICINES HAVE YOU TAKEN IN THE PAST? WHEN?**

Medication Year(s) Taken 19__ to 20__	**Medication Year(s) Taken 19__ to 20__**
Antidepressants	**Anti-Anxiety Medications**
Anafranil (clomipramine)	Atarax / Vistaril (hydroxyzine)
Celexa (citalopram)	Ativan (lorazepam)
Cymbalta (duloxetine)	Buspar (buspirone)
Effexor (venlafaxine)	Klonopin (clonazepam)
Elavil (amitriptyline)	Librium (chlordiazepoxide)
Lexapro (escitalopram)	Valium (diazepam)
Luvox (fluvoxamine)	Xanax (alprazolam)
Pamelor (nortriptyline)	Other Anti-Anxiety (Name ____________________)
Paxil (paroxetine)	**Mood Stabilizers / Anti-Epilepsy Drugs**
Pristiq (desvenlafaxine)	Depakote (valproate)
Prozac / Sarafem (fluoxetine)	Dilantin (phenytoin)
Remeron (mirtazapine)	Eskalith / Lithobid (lithium)
Serzone (nefazodone)	Keppra (levetiracetam)
Viibryd (vilazodone)	Lamictal (lamotrigine)
Wellbutrin / Zyban (bupropion)	Neurontin (gabapentin)
Zoloft (sertraline)	Tegretol / Carbatrol / Equetro (carbamazepine)
Other Antidepressant (Name ____________________)	Topamax (topiramate)
Antipsychotics	Trileptal (oxcarbazepine)
Abilify (aripiprazole)	Other Mood Stabilizer / AED (Name __________________)
Fanapt (iloperidone)	**Stimulants / ADHD Medications**
Geodon (ziprasidone)	Adderall (amphetamine mixture)
Haldol (haloperidol)	Cylert (pemoline)
Invega (paliperidone)	Dexedrine (dextroamphetamine)
Latuda (lurasidone)	Focalin (dexmethylphenidate)
Risperdal (risperidone)	Intuniv / Tenex (guanfacine)
Saphris (asenapine)	Meridia (sibutramine)
Seroquel (quetiapine)	Provigil (modafinil)
Zyprexa (olanzapine)	Ritalin / Concerta / Metadate (methylphenidate)
Other Antipsychotic (Name ____________________)	Strattera (atomoxetine)
	Vyvanse (lisdexamfetamine)
	Other ADHD Medication (Name ____________________)
Sleep Medications	
Ambien (zolpidem)	Rozerem (ramelteon)
Desyrel (trazodone)	Sinequan (doxepin)
Lunesta (eszopiclone)	Sonata (zaleplon)
Melatonin	Unisom (doxylamine)
ProSom (estazolam)	Other Sleep Medication (Name ____________________)
Restoril (temazepam)	

◆ **WHAT TREATMENT OR COMBINATION OF TREATMENTS HAS WORKED BEST FOR YOU?**

____

____

____

____

____

____

OFFICE USE - Name:	DOB:	MRN:

Drug & Alcohol History

Drug Name	Age of 1st Use	Current Amt/Freq	Peak Amt/Freq	Last Use
MARIJUANA				
COCAINE				
ALCOHOL				
SEDATIVES BARBITURATES, BENZODIAZEPINES				
HALLUCINOGENS LSD, PCP, ACID				
AMPHETAMINES UPPERS, SPEED, CRANK, ICE, 8-BALLS				
NARCOTICS HEROIN, OXYCODONE, ETC.				
INHALANTS GASOLINE, GLUE, PAINT THINNER, WHITE-OUT, HUFFING				

- **TREATMENT FOR DRUG OR ALCOHOL ABUSE:** LIST LOCATIONS, DATES OF TREATMENT, DURATION.

  INPATIENT DETOX____

  LONG-TERM RESIDENTIAL____

  OUTPATIENT____

- **LEGAL PROBLEMS RELATED TO DRUG/ALCOHOL USE:** ______________________________

- **WITHDRAWAL SYMPTOMS / MEDICAL PROBLEMS FROM DRUG/ALCOHOL USE:** ______________

Family Psychiatric History

- **HAVE ANY OF YOUR FAMILY MEMBERS BEEN DIAGNOSED WITH ANY OF THE FOLLOWING?**

MAJOR DEPRESSION	NONE	MOTHER	FATHER	SIBLING: BRO / SIS	CHILD: SON / DAU	GRAND-PARENT	OTHER
POSTPARTUM DEPRESSION	NONE	MOTHER	FATHER	SIBLING: BRO / SIS	CHILD: SON / DAU	GRAND-PARENT	OTHER
BIPOLAR DISORDER / MANIC DEPRESSION	NONE	MOTHER	FATHER	SIBLING: BRO / SIS	CHILD: SON / DAU	GRAND-PARENT	OTHER
GENERALIZED ANXIETY DISORDER	NONE	MOTHER	FATHER	SIBLING: BRO / SIS	CHILD: SON / DAU	GRAND-PARENT	OTHER
PANIC DISORDER	NONE	MOTHER	FATHER	SIBLING: BRO / SIS	CHILD: SON / DAU	GRAND-PARENT	OTHER
OBSESSIVE COMPULSIVE DISORDER	NONE	MOTHER	FATHER	SIBLING: BRO / SIS	CHILD: SON / DAU	GRAND-PARENT	OTHER
SOCIAL ANXIETY DISORDER	NONE	MOTHER	FATHER	SIBLING: BRO / SIS	CHILD: SON / DAU	GRAND-PARENT	OTHER
POSTTRAUMATIC STRESS DISORDER	NONE	MOTHER	FATHER	SIBLING: BRO / SIS	CHILD: SON / DAU	GRAND-PARENT	OTHER
SCHIZOPHRENIA	NONE	MOTHER	FATHER	SIBLING: BRO / SIS	CHILD: SON / DAU	GRAND-PARENT	OTHER
SCHIZOAFFECTIVE DISORDER	NONE	MOTHER	FATHER	SIBLING: BRO / SIS	CHILD: SON / DAU	GRAND-PARENT	OTHER
ANOREXIA / BULIMIA NERVOSA	NONE	MOTHER	FATHER	SIBLING: BRO / SIS	CHILD: SON / DAU	GRAND-PARENT	OTHER
ALCOHOL ABUSE / DEPENDENCE	NONE	MOTHER	FATHER	SIBLING: BRO / SIS	CHILD: SON / DAU	GRAND-PARENT	OTHER
ANY SUBSTANCE ABUSE / DEPENDENCE	NONE	MOTHER	FATHER	SIBLING: BRO / SIS	CHILD: SON / DAU	GRAND-PARENT	OTHER
ATTENTION DEFICIT/HYPERACTIVITY D/O	NONE	MOTHER	FATHER	SIBLING: BRO / SIS	CHILD: SON / DAU	GRAND-PARENT	OTHER
BORDERLINE PERSONALITY DISORDER	NONE	MOTHER	FATHER	SIBLING: BRO / SIS	CHILD: SON / DAU	GRAND-PARENT	OTHER
OTHER MENTAL ILLNESS (____________)	NONE	MOTHER	FATHER	SIBLING: BRO / SIS	CHILD: SON / DAU	GRAND-PARENT	OTHER

OFFICE USE - Name:	DOB:	MRN:

Your Current Status

- **LIST ALL MEDICINES, VITAMINS, & HERBS YOU ARE CURRENTLY TAKING**:

Name of Medication	Dose	How often	Reason for Medication

- **ARE YOU USING TOBACCO?** YES NO How many cigarettes per day? ______________
- **HOW MANY CAFFEINATED BEVERAGES DO YOU DRINK PER DAY?**________________
- **ARE YOU CURRENTLY HAVING PROBLEMS WITH ANY OF THE FOLLOWING SYMPTOMS?**

__Sad Mood / Tearfulness
__No Pleasure
__No Energy
__Sleep Disturbance
__Appetite Disturbance
__Low Self-esteem
__Guilt
__Poor concentration

__Worry
__Panic attacks
__Fear of crowds
__Fear of germs
__Intrusive thoughts
__Compulsions
__Nightmares
__Flashbacks

__Elated/Manic Mood
__Rapid Speech
__Impulsive
__Hallucinations
__Suicidal Thoughts
__Violent Thoughts

__Severe nausea
__Migraine headaches

- **WHAT'S THE MAIN CONCERN OR QUESTION THAT YOU WANT TO DISCUSS WITH US?**

____
____
____
____
____
____
____
____
____
____