OFFICE USE - Name:	DOB:	MRN:

EMORY UNIVERSITY SCHOOL OF MEDICINE

Women's Mental Health Program

Department of Psychiatry and Behavioral Sciences

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
- **YOUR BIRTH DATE**____/____/____
- **RACIAL BACKGROUND**
  - African American / African / Black
  - Asian / Indian
  - Caucasian
  - Native American / Alaska Native
  - Pacific Islander
  - More than one race
  - Other_____
- **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)
- **YOUR OCCUPATION**

  _____

- **GENDER OF YOUR SPOUSE/PARTNER**
  - Male
  - Female
- **PARTNER'S BIRTH DATE**____/____/_____
- **PARTNER'S RACIAL BACKGROUND**
  - African American / African / Black
  - Asian / Indian
  - Caucasian
  - Native American / Alaska Native
  - Pacific Islander
  - More than one race
  - Other_____
- **PARTNER'S ETHNICITY**
  - Hispanic
  - Not Hispanic
- **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)
- **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

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

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____