EMORY WOMEN'S MENTAL HEALTH PROGRAM
INTAKE PACKET

Thank you for taking the time to fill out these forms. Please answer the questions to the best of your ability. The information we collect will be helpful to your clinician and provide the cornerstone for future preventative studies. The information gathered here will be kept strictly confidential.

NAME:____ **DATE:**____/____/____ **AGE:**________
ADDRESS: ____
____
PHONE NOS. - HOME: ____________________ **CELL:** ____________________ **WORK:** ____________________
EMAIL: ____ **SSN:** ____

General Information

- **MARITAL STATUS**
  - Never married / living alone
  - Never married / living with partner ____ (how long)
  - Married _____(how long) _____ (number of times)
  - Separated _____(how long)
  - Divorced
  - Widowed

- **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
  - 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
  - Bachelor's degree
  - Some graduate school
  - Masters degree
  - Doctoral degree (PhD, MD, JD, EdD, etc)

- **YOUR OCCUPATION**
  ____

- **PARTNER'S OCCUPATION**
  ____

- **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
  - Unemployed but able to work
  - Doing volunteer work
  - Unable to work
  - Other (describe) ____________________

- **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) ____________________

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

- **YOUR HEIGHT** (ft., in.) __________

- **YOUR PRE-PREGNANCY WEIGHT** (lbs) _____

- **RELIGIOUS AFFILIATION**______________________________

Gynecological History

- **YOUR OB/GYN'S NAME / 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, medication seldom needed
  Moderate cramps, medication usually needed
  Severe cramps, medication and bed rest needed

- **HOW REGULAR IS YOUR MENSTRUAL CYCLE?**

  Regular _____ (average number of days per cycle)
  Irregular

- **DO YOU HAVE A HISTORY OF PMS?** YES NO

- **HAVE YOUR PERIODS EVER STOPPED TEMPORARILY?** YES NO

  If yes, mark which event caused your periods to stop and how long:

  Sudden weight loss
  Hormonal Medication [Lupron (Luprolide), Danocrine (Danzol), Synarel (Nafareline), Depo-provera]
  Low body fat
  Chemotherapy/radiation treatments
  Unexplained
  Other ___________________________

- **HAVE YOU EVER BEEN TOLD THAT YOU HAD ANY OF THE FOLLOWING CONDITIONS?**

  Sexually Transmitted Disease
  Endometriosis
  Polycystic Ovaries
  Pelvic Inflammatory Disease
  Fibroid Uterus
  Fibrocystic Breast Disease
  Breast Cancer
  Multiple Abnormal PAP smears

- **ARE YOU CURRENTLY SEXUALLY ACTIVE?** YES NO

- **WHAT KIND OF BIRTH CONTROL ARE/WERE YOU CURRENTLY USING?**____________

- **WHAT BIRTH CONTROL METHODS HAVE YOU USED IN THE PAST AND WHEN?**

  METHOD: YEARS:

____
____
____

Obstetrical History

- **HOW MANY TIMES HAVE YOU BEEN PREGNANT?** (including current 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?** . . . . ____
- **DID YOU EVER TRY FOR > 2 YEARS TO GET PREGNANT OR HAVE REPEATED PROBLEMS CARRYING A PREGNANCY?** YES NO
- **HAVE YOU EVER USED FERTILITY MEDICATIONS SUCH AS CLOMID OR PERGANOL? WHAT WAS THE NAME OF THE MEDICATION?** ____

Current /Most Recent Pregnancy

- **WAS THIS PREGNANCY PLANNED?** YES NO
- **WAS THIS PREGNANCY DESIRED?** YES NO MIXED FEELINGS
- **WHAT WAS THE FIRST DAY OF YOUR LAST MENTRUAL PERIOD?** ______/______/______
- **WHAT IS YOUR ESTIMATED DATE OF DELIVERY?** ______/______/______
- **WHAT WEEK OF YOUR <u>PREGNANCY</u> DID YOU BEGIN FEELING DOWN?** ______________________
  <u>OR</u> WHAT WEEK <u>POSTPARTUM</u> DID YOU BEGIN FEELING DOWN? ______________________
- **PLEASE LIST ANY MEDICATIONS (OVER THE COUNTER & PRESCRIPTIONS) TAKEN DURING YOUR PREGNANCY.** ____
  ____

Delivery & Postpartum

If you are currently pregnant, please skip this section.

- **BABY'S DATE OF BIRTH** ____/____/____
- **BABY'S SEX:** MALE FEMALE
- **BIRTH WEIGHT** ______________
- **LENGTH** ____________
- **HEAD CIRCUMFERENCE**________
- **APGAR SCORES:** ______ & ______
- **PLEASE LIST ANY DELIVERY COMPLICATIONS.** ____
  ____
- **HOW LONG WERE YOU HOSPITALIZED FOR DELIVERY?** ___________________________________

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

METHOD:	MONTHS:
Bottle/Formula	____________________
Breastfeeding	____________________
Both	____________________
Other: _______________	____________________

- **PEDIATRICIAN'S NAME AND ADDRESS:** ____

____

- **HAS YOUR MENSTRUAL CYCLE RETURNED?** YES NO
- **DID YOU HAVE ANY HELP WITH THE BABY AFTER THE HOSPITAL?**
  NO YES, WHO? ____

Psychiatric History

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

____

____

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

____

- **PREVIOUS OUTPATIENT PSYCHIATRIC TREATMENT? WHERE AND WHEN? FOR WHAT PERIOD OF TIME?**

____

- **PREVIOUS PSYCHIATRIC HOSPITALIZATIONS? WHERE AND WHEN? FOR WHAT PERIOD OF TIME?**

____

- **HAS A PROFESSIONAL, FRIEND, OR FAMILY MEMBER EVER SAID YOU WERE DEPRESSED OR HAD ANXIETY?** NO YES, WHO? ____

- **HAVE YOU EVER SOUGHT TREATMENT FOR DEPRESSION OR ANXIETY?** YES NO
- **HAVE YOU EVER HAD PSYCHOTHERAPY AS YOUR MAIN TREATMENT?** YES NO
- **HAVE YOU EVER SOUGHT TREATMENT FOR ANY OTHER PSYCHIATRIC CONDITION?**
  YES NO IF YES, WHAT? ____
- **HAVE YOU EVER BEEN TOLD BY A CLINICIAN THAT YOU HAVE ANY OF THE FOLLOWING:**

Major Depression
Postpartum Depression
Dysthymic Disorder
PMS / Premenstrual Depression
Bipolar Disorder / Manic Depression

Generalized Anxiety Disorder
Panic Disorder
Obsessive Compulsive Disorder
Social Anxiety Disorder
Posttraumatic Stress Disorder
Any Other Anxiety Disorder

Other, Please Specify ______________________________

Schizophrenia
Schizoaffective Disorder
Any Other Psychotic Disorder

Anorexia Nervosa
Bulimia Nervosa
Any Other Eating Disorder

Alcohol Abuse or Dependence
Cocaine Abuse or Dependence
Any Other Substance Abuse Disorder

Migraine Headaches

- **WHICH OF THE FOLLOWING PSYCHIATRIC MEDICINES HAVE YOU TAKEN IN THE PAST?**

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)
Desyrel (trazodone)	Buspar (buspirone)
Effexor (venlafaxine)	Klonopin (clonazepam)
Elavil (amitriptyline)	Librium (chlordiazepoxide)
Lexapro (escitalopram)	Valium (diazepam)
Luvox (fluvoxamine)	Xanax (alprazolam)
Norpramine (desipramine)	Other Anti-Anxiety (Name ___________)
Pamelor (nortriptyline)	**Mood Stabilizers / Anti-Epilepsy Drugs**
Paxil (paroxetine)	Depakote (valproate)
Prozac / Sarafem (fluoxetine)	Dilantin (phenytoin)
Remeron (mirtazapine)	Eskalith / Lithobid (lithium)
Serzone (nefazodone)	Keppra (levetiracetam)
Sinequan (doxepin)	Lamictal (lamotrigine)
Tofranil (imipramine)	Neurontin (gabapentin)
Wellbutrin / Zyban (bupropion)	Tegretol / Carbatrol (carbamazepine)
Zoloft (sertraline)	Topamax (topiramate)
Other Antidepressant (Name ___________)	Trileptal (oxcarbazepine)
Antipsychotics	Other Mood Stabilizer / AED (Name ___________)
Abilify (aripiprazole)	**Stimulants / ADHD Medications**
Clozaril (clozapine)	Adderall (amphetamine mixture)
Geodon (ziprasidone)	Cylert (pemoline)
Haldol (haloperidol)	Dexedrine (dextroamphetamine)
Risperdal (risperidone)	Meridia (sibrutamine)
Seroquel (quetiapine)	Provigil (modafinil)
Zyprexa (olanzapine)	Ritalin / Concerta / Metadate (methylphenidate)
Other Antipsychotic (Name ___________)	Other Stimulant (Name ___________)
Sleep Medication	
Ambien (zolpidem)	
Lunesta ( )	
ProSom (estazolam)	
Restoril (temazepam)	
Sonata (zaleplon)	
Other Sleep Medication (Name ___________)	

Drug & Alcohol History

- **CURRENT USE OR USE IN PREGNANCY?** YES__ NO__
- **PAST USE OF DRUGS & ALCOHOL?** YES__ NO__

IF YES, WHICH OF THE FOLLOWING:

Drug Name	Age of 1st Use	Current Amt/Freq	Peak Amt/Freq	Last Use

MARIJUANA____

REEFER, HASHISH, BLUNTS, JOINTS, WEED, GRASS

COCAINE____

POWDER, FREEBASED,CRACK, IN JOINT (GEEK JOINTS) OR CIGARETTE, IV

ALCOHOL____

WINE, BEER, LIQUOR

SEDATIVES____

BARBITURATES, BENZODIAZEPINES, QUAALUDES, DOWNER'S

HALLUCINOGENS____

LSD, PCP, ACID

AMPHETAMINES____

UPPERS, SPEED, CRANK, ICE, 8-BALLS

NARCOTICS____

HEROIN, PERCODAN, DEMORAL, DILAUDID, METHADONE

INHALANTS____

GASOLINE, GLUE, PAINT THINNER, WHITE-OUT, HUFFING

TOBACCO____

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

INPATIENT DETOX____

LONG-TERM RESIDENTIAL____

OUTPATIENT____

NA/AA MEETINGS____

- **LONGEST PERIOD OF SOBRIETY:** ____
- **LEGAL PROBLEMS RELATED TO DRUG/ALCOHOL USE:** ____
- **WITHDRAWAL SYMPTOMS / MEDICAL PROBLEMS FROM DRUG/ALCOHOL USE:** ________________

____

- **LOSS OF JOB, CHILD CUSTODY, RELATIONSHIP DUE TO DRUG/ALCOHOL USE:** ________________

____

Family Psychiatric History

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

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

Current Status

- **ARE YOU CURRENTLY SEEING A PSYCHIATRIST/THERAPIST? WHO? WHERE?**

____

- **WHAT PSYCHIATRIC MEDICATIONS ARE YOU CURRENTLY TAKING? AT WHAT DOSE?**

____
____
____

- **LIST ALL PRESCRIPTION MEDICINES, OVER-THE-COUNTER MEDICINES, VITAMINS, & HERBS YOU HAVE TAKEN IN THE LAST MONTH**: ______________________________

____
____
____

- **MEDICATION ALLERGIES:** ____

What was the reaction? ____

When did this occur (age or year)? _______________________________

- **DO YOU HAVE OTHER CHILDREN? WITH WHOM DO THEY LIVE? EVER LOST CUSTODY?**

____
____

- **CURRENT OR PAST CHILD PROTECTIVE SERVICES (DFACS) INVOLVEMENT?**

____

____

- **ARE YOU CURRENTLY HAVING PROBLEMS WITH ANY OF THE FOLLOWING SYMPTOMS?**

__Sad Mood	__Suicidal Ideation	__Agoraphobia	__Irritability
__Tearfulness	__Homicidal Ideation	__Nightmares	__Hyperactive/Impulsive
__No Pleasure	__Low Self-esteem	__Flashbacks	__Confused Thinking
__No Energy	__Poor Concentration	__Obsessions	__Disorganization
__Sleep Disturbance	__Anxiety/Worry	__Compulsions	__Hallucinations
__Appetite Disturbance	__Panic Attacks	__Elation/Mania	__Delusion

- **ANY OTHER SPECIAL PROBLEMS OR STRESSES CURRENTLY?**

____

____

Cancellation Policy

Since the majority of our patients have children and very busy schedules, we understand that occasionally it may be necessary to cancel an appointment. We do not bill for cancellations as we typically have a waiting list, but we ask that you call at least 24 hours prior to your appointment to cancel. If you do not cancel an appointment within 24 hours, it is considered a "missed" appointment. It is the policy of the Emory Women's Mental Health Program to terminate your care after two missed appointments.

I have read and understand the cancellation policy of the Emory Women's Mental Health Program.

____ ____/____/____

Signature **Date**

Rev. 8/31/05