Perinatal Mental Health Intake Form

Full Name

Date of Birth

Phone Number

Email

Current Pregnancy/Birth Status

Due Date / Birth Date

Weeks Gestation (if pregnant)

Obstetric Provider

Mental Health History (personal, family, prior diagnoses, hospitalizations, treatments)

Current Mental Health Concerns/Symptoms

Current Medications (include doses and prescriber)

Substance Use (alcohol, tobacco, drugs, caffeine)

Significant Medical History

History of Trauma

Support System (partner, family, friends, community)

Personal Goals for Care

Any Other Concerns or Notes