

Perinatal Mental Health Assessment Intake Form

Demographic Information

Full Name

Date of Birth

Phone Number

Email Address

Address

Obstetric/Medical History

Current Pregnancy Status

Gestational Age (weeks) / Postpartum (weeks)

Number of Pregnancies

Complications (Current or Past)

Mental Health History

Current Symptoms

Previous Mental Health Diagnoses

Current Medications

Previous Therapy or Counseling

Psychosocial Assessment

Support System

Current Stressors

Substance Use (Tobacco, Alcohol, Drugs)

History of Domestic Violence

Risk Assessment

Any Current Thoughts of Self-harm or Suicide?

Any Intent to Harm Others?

If Yes, Please Provide Details

Other Notes

Additional Information