

DOOR of HOPE COUNSELING

BACKGROUND FORM (Mothers seen for Postpartum Issues)

Please answer all information as completely as possible. Information given is strictly confidential and beneficial in providing the best possible service. Feel free to ask for assistance, if needed. Your counselor will discuss your responses with you after the form is reviewed.

GENERAL INFORMATION

Name: _____ Date of First Visit: _____
Last First MI

Home Phone: _____ (May call? Yes No May Leave Message? Yes No)

Work Phone: _____ (May call? Yes No May Leave Message? Yes No)

Cell Phone: _____ (May call? Yes No May Leave Message? Yes No)

Text Number: (if different from cell) _____ (May text? Yes No)

Best Time and Place to call: _____

Email: _____ (May Email? Yes No)

Address: _____
Street City State Zip

Gender: _____ Age _____

Date of Birth: _____ Occupation: _____

Employer: _____ How Long: _____

Ethnicity:
 African American Bi-racial Hispanic/Latin
 Asian Caucasian Native American Other _____

How did you hear about us? Website Previous Client School Doctor Friend Church Other: _____

Are you presently receiving counseling elsewhere? Yes No
(If yes, do not complete this form until you have talked with your counselor)

Have you ever seen a mental health professional (psychiatrist, psychologist, or a counselor)? Yes No
(If so, we will need your permission in order to communicate with that individual or agency)

Previous Mental Health Professional/Agency: _____

Phone: _____ Dates of Service: _____ (beginning - ending)
Name Address

Previous Mental Health Professional/Agency: _____

Name Address

Phone: _____ Dates of Service: _____ (beginning - ending)
Please list additional at the bottom of this form if necessary.

Have you ever been hospitalized for mental health concerns? Yes No

If yes: When _____ Where _____

Are you seeking services because you are a victim of a crime? Yes No

Did it result in legal action? Yes No (If Yes, explain) _____

Education Level:

___ 8th grade or below ___ High School ___ GED
___ Trade School/Some College ___ Undergraduate Degree ___ Graduate Degree

Current living arrangements:

___ Family of origin ___ Single ___ Spouse/Partner ___ Roommate ___ Other _____

Marital Status (indicate all that apply and duration of each, ex. 1965-1985):

___ Never married ___ Currently married ___ Divorced ___ Widowed

Marital History

___ Number of Marriages ___ Number of Divorces

List your current family, beginning with the oldest member:

Primary Household (anyone who currently lives in your household)

How long in this current living situation: _____

Name	Age	Gender	Relationship to you
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

RELIGION / SPIRITUALITY

Does religious faith play an important part in the life of your family? Yes No

If so, what faith community do you belong/attend: _____

What religious/spiritual activities does your family participate in? For example, daily prayer, reading of scripture, etc.

HEALTH

Date of LAST complete physical: _____

Physical Disability: Yes No (If yes, explain) _____
 Chronic Illness: Yes No (If yes, explain) _____
 Terminal Illness: Yes No (If yes, explain) _____

Check the following items for a diagnosis or medication that you are now receiving or have received:

Diagnosis	Current (list dates)	Past (list dates)	Physician's Name	Name of medication	Dosage
Depression	_____	_____	_____	_____	_____
ADHD	_____	_____	_____	_____	_____
ADD	_____	_____	_____	_____	_____
Conduct Disorder	_____	_____	_____	_____	_____
Anxiety/ Nervousness	_____	_____	_____	_____	_____
Bipolar	_____	_____	_____	_____	_____
Schizophrenia	_____	_____	_____	_____	_____
Oppositional Defiant Disorder	_____	_____	_____	_____	_____
Mood/Anger	_____	_____	_____	_____	_____
Tics	_____	_____	_____	_____	_____
Insomnia/ Sleeplessness	_____	_____	_____	_____	_____
Obsessive/ Compulsive	_____	_____	_____	_____	_____
Seizures	_____	_____	_____	_____	_____
Post-Traumatic Stress Disorder	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____

(If you do not know the name and dosage of current medication, please bring the medication to your next session)

What other medication are you currently taking?

Medication	Dosage	Taken for what reason?
_____	_____	_____
_____	_____	_____
_____	_____	_____

PREGNANCY & POSTPARTUM QUESTIONS

PREGNANCY

Are you currently pregnant? Yes No

(If Yes, how far along are you?) _____

(If Yes, are you currently taking any medication, drugs, or alcohol) _____

(If Yes, Was this a planned pregnancy?) Yes No

Please list your number of pregnancies along with the year, and if the pregnancy resulted in a miscarriage, stillbirth, or live birth

Do you have a history of infertility? Yes No

(If Yes, did you take any fertility medication?) _____

During this time of pregnancy or while you were pregnant, what is/was the most troubling for you (physically and emotionally)

POSTPARTUM & ADOPTION

Briefly share your child's birth or adoption story

Please share how you are feeding your baby (i.e. bottle, formula, breastfeeding, pumping)

Briefly explain your sleep habits after bringing your baby home (i.e. how much uninterrupted sleep are you getting per night on average, who sleeps where in the home, and who wakes up with the baby)

Circle any items that you are currently experiencing or did experience after giving birth/adopting

Physical

Loss of appetite

Hyperactivity

Intense weight gain or loss

Low energy

Insomnia

Physical pain

Difficulty having sex/low sex drive

Mood-Related

Crying/Sadness

Anger

Worrying

Irritability

Feeling withdrawn

Feeling overwhelmed

Mood swings

Lack of joy/pleasure

Cognition

- Inability to focus or concentrate
- Hearing voices
- Thoughts of harm to your child
- Disturbing memories/reliving the birth

Feelings of guilt or shame

Suicidal thoughts

Feeling hopeless

Family Relationship/Adjustment

- Marital concerns
- Parent-child relationship problems
- Sibling concerns
- Divorce/Separation
- Grief/Loss
- Difficulty adjusting to family change
- Recent move

Religious/Spiritual

Current or past spiritual abuse

Recent changes in belief/churches

What is your main/most significant issue? _____

How have you attempted before now to deal with this issue? _____

FAMILY HISTORY

That you know of, have any women in your family experienced Postpartum depression or anxiety?

Please list your family history of mental illness (diagnosed or not)

HISTORY OF TRAUMA and/or STRESSORS

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** ...swear at you, insult you, put you down, or humiliate you? **Or**, act in a way that made you afraid that you might be physically hurt?
Yes No
2. Did a parent or other adult in the household **often** ...push, grab, slap, or throw something at you? **Or**, ever hit you so hard that you had marks or were injured?
Yes No
3. Did an adult or person at least 5 years older than you **ever**...touch or fondle you or have you touch their body in a sexual way? **Or**, Try to or actually have oral, anal, or vaginal sex with you?
Yes No
4. Did you **often** feel that ...no one in your family loved you or thought you were important or special? **Or**, your family didn't look out for each other, feel close to each other, or support each other?
Yes No
5. Did you **often** feel that ...you didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? **Or**, your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
Yes No

6. Were your parents **ever** separated or divorced?
Yes No
7. Was your mother or stepmother: **Often** pushed, grabbed, slapped, or had something thrown at her? **Or, sometimes or often** kicked, bitten, hit with a fist, or hit with something hard? **Or ever** repeatedly hit over at least a few minutes or threatened with a gun or knife?
Yes No
8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
Yes No
9. Was a household member depressed or mentally ill or did a household member attempt suicide?
Yes No
10. Did a household member go to prison?
Yes No

History of learning, emotional, behavioral problems: Yes No
(If yes, please explain) _____

History of alcohol/drug/substance abuse: Yes No
(If yes, please explain) _____

History of family violence: Yes No
(If yes, please explain) _____

History of criminal activity in the family: Yes No
(If yes, please explain) _____

Has you been abused (check all that apply): _____ Physically _____ Emotionally _____ Sexually _____ Spiritually

History of health/physical problems includes: (check all that apply):

_____ Asthma	_____ Nervous stomach
_____ Bedwetting	_____ Dizziness
_____ Neurological problems/exam	_____ Severe Headaches
_____ Severe PMS	_____ Chest pain
_____ Heart Palpitations	_____ Serious overeating/under-eating
_____ Shortness of breath without exertion	_____ Major accident
_____ Sleep problems	_____ Chronic Diarrhea
_____ Surgeries	_____ Other _____

Anything else you think we need to know? _____

What is the one thing we need to know to help you today? _____

ANY OTHER INFORMATION YOU THINK WOULD BE HELPFUL

Thank you.