Information Form

Your Name: _____

Partner's Name (if applicable): _____Relationship status: _____

Contact information

Cell/personal phone number: _____

Check one: □ It is OR □ It is NOT acceptable to call and leave a message at the phone number(s) listed above.

Full address: _____

City: _____ State: _____ Zip code: _____

Occupation: _____

Name of someone to contact in an emergency situation: _____

Full address: _____

Phone number(s): _____

Please describe any past or current experiences of domestic violence. If none, please write "none." _____

_____

_____

What questions or concerns do you want to be certain to address during this consultation session? _____

_____

_____

_____

_____

Do you feel any undue pressure to use donor eggs/sperm and move forward with fertility treatment?

(circle) Yes No

□ Yes □ No It is acceptable for Jennifer Moné to send information by mail (such as surveys or other information) during or after our session together. *Your name will never be shared with anyone.*

Personal Background and Family Information

Please write legibly; each person must complete a separate form

Names of Recipients:

Your name:

Partner (if applicable):

Have you selected a donor yet? _____ If yes, is your donor a (circle one)

Conceptions donor

Agency donor

Known donor

Identifying Information:

Your age: _____ DOB: _____

Gender identity: M F Other (list) Assigned sex (@ birth): M F Other (list)

Please list your family ancestry/national heritage:

Do you have a history of previous marriage (or significant partnerships)? _____ If so, please indicate when each one started and its end date.

Do you have any children? _____ If so, please list their sex and age(s).

Please describe your own personality using 3-5 descriptor words:

What are your hobbies?

In the last 5 years, have you experienced any legal issues (such as court cases, arrests, probation, etc.)? _____ If so, please briefly describe:

Education and Employment History:

Please list high school attended, location, and date of graduation, if no college degree:

Name of undergraduate college attended:

Major:

Year graduated:

List any postgraduate education and universities:

Major:

Degree conferred? Date:

Have you experienced any history of a diagnosed learning disability? _____ If so, please describe:

Please list your current employer, position, and length of time you have been in your position:

List a brief employment history if currently not employed or if you have experienced a job change in the recent past:

Family History:
Where were you born? (Please list city, state, and country)

Where were you raised? (Please list city, state, and country)

Are your parents (circle all that apply) married / divorced / deceased / other:_____.

Please list the amount of time your parents have been married, when divorced, or deceased:

Please list your siblings, include birth order and gender (note whether sibling is ½ or full biological):

Briefly describe your family relationships; how would you characterize them?

Do you practice any particular religious faith or spirituality? _____ If so, please list:

Please describe how you feel about pursuing fertility treatment given your particular religion, faith, morals, and values, etc.:

Medical and Mental Health History:
Have you ever smoked or used tobacco on a frequent or regular basis? _____ If yes, please describe your age when tobacco use began, if/when it stopped, and amount of use per day:

Please describe any other drug or substance use (what type and how often):

Please list any medications you are currently taking, including over-the-counter, prescription, and psychiatric medications:

Medication *Dosage* *Reason for taking*

_____

_____

_____

_____

Please list your average frequency for alcohol consumption: _____ drinks per day / week / month (circle one)

How many drinks do you consume at a time (at each sitting): _____

Please list your average intake of caffeine: _____ drinks per day / week / month (circle one)

Please list all important events you have experienced in the last 12 months:

Check any of the following you have experienced in the last year:

_____ Irritability
_____ Fatigue
_____ Sexual concerns
_____ Sleep problems
_____ Change in eating habits
_____ Major weight change
_____ Difficulty breathing
_____ Excessive stress
_____ Depression
_____ Anxiety or nervousness
_____ Problems concentrating
_____ Attempted suicide
_____ Seen violence against self/others
_____ Had intrusive thoughts/sounds
_____ Physical or sexual abuse
_____ Thoughts about suicide
_____ Lack of ambition
_____ Poor appetite
_____ Inability to relax
_____ Thoughts of hurting others
_____ Loneliness
_____ Legal problems
_____ Feeling inferior
_____ Fears (specify)
_____ Financial problems
_____ Friendship difficulties
_____ Marriage/partner concerns
_____ Being isolated from others
_____ Feeling financially controlled
_____ Other (list)

Were you ever:

	Yes	No	What ages?	How often?
Physically Abused	____	____	_____	_____
Sexually Abused	____	____	_____	_____
Emotionally Abused	____	____	_____	_____
Diagnosed with a mental illness	____	____	_____	which: _____

Have you ever:

	Yes	No	What ages?	How often?
Attempted suicide	____	____	_____	_____
Abused alcohol	____	____	_____	_____
Abused substances/drugs	____	____	_____	_____
Experienced an eating disorder	____	____	_____	_____
Been hospitalized for mental health reasons	____	____	_____	_____

Other trauma that you experienced:

Have you ever seen a counselor or mental health professional? _____If yes, please describe the issues addressed and indicate when the sessions occurred.

Have any of your family members (e.g., parents, siblings) had a history of:

	Yes	No	Who? (e.g. father, sister, etc.)
Diagnosed Emotional Problems	____	____	_____
Suicide	____	____	_____
Severe Trauma	____	____	_____
Alcoholism	____	____	_____
Drug/Substance Abuse	____	____	_____

<u>Current Support Systems</u> (please list)

Church _____

Group (e.g. therapy, 12-step) _____

Friends _____

Family _____

Other _____