Women's Health Innovations of Arizona-
INTAKE QUESTIONNAIRE

Personal Information

Name: _____ Date: _____

Address: _____
Street City State ZIP

SS #: _____ Date of Birth: _____/_____ / _____

Home Phone: _____ Cell Phone: _____

How did you hear about us? _____

Are you? *(circle one)* Married Single Divorced Separated Widowed Co-habitating

Not including yourself, list the names, ages, and relationship of individuals who live with you:

Name	Age	Relationship	Name	Age	Relationship
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Military service? ..... Yes No If yes, service dates: ___ /___- ___ /___

Any military problems? ..... Yes No Financial problems? ..... Yes No

Legal problems? ..... Yes No Family problems? ..... Yes No

Cultural/spiritual problems? ..... Yes No Social support system problems? .. Yes No

Employment problems? ..... Yes No Living/housing problems? ..... Yes No

If yes to any of the above, please explain: _____
_____
_____
_____

Are you employed? No Full-time Part-time Where? _____

What is your religious preference? _____

Is this a source of support for you? Yes No

Briefly explain why you are seeking counseling today: _____
_____
_____
_____
_____

How long has this been a problem? _____

Emergency Contact Information

Name: _____ Phone: _____

Address: _____
Street City State ZIP

Relationship to You: _____

Pregnancy / Postpartum Information

Please indicate if you have ever experienced any of the following. *(check all that apply)*

- ❑ Postpartum depression or anxiety (Me)
- ❑ Postpartum depression or anxiety (Family Member)
- ❑ Abrupt weaning
- ❑ Social isolation or poor support
- ❑ History of premenstrual syndrome (PMS)
- ❑ Mood changes while taking birth control pills or fertility medication
- ❑ Thyroid dysfunction
- ❑ History of infertility
- ❑ History of miscarriage, abortion, or fetal/infant loss

Explain any issues you checked above: _____
_____
_____
_____
_____
_____

Psychiatric / Medical Information

Have you had any previous psychological consultations? Yes No

Have you ever been hospitalized for psychiatric reasons? Yes No

Are you currently using any other psychiatric/psychological support systems? Yes No

Are you now, or have you ever been, on any psychiatric medications? Yes No

If yes, name of psychiatrist: _____ Phone: _____

Medication	Dosage	Frequency	Start Date	Side Effects	Helpful?
_____	_____	_____	_____	_____	Yes No
_____	_____	_____	_____	_____	Yes No
_____	_____	_____	_____	_____	Yes No
_____	_____	_____	_____	_____	Yes No

Do you have any current or past medical problems? Yes No

Are you currently taking any **non**-psychiatric medications? Yes No

If yes to either question, please explain: _____
_____
_____
_____
_____
_____