Therapy Center for Pregnancy Loss
Rayna D. Markin, PhD

Initial Interview

I. Identifying Information:

Name:

Address:

Telephone (home)
Telephone (work)
Telephone (cell)

Email address:

Please indicate if I should not leave a private message at any of the phone numbers or email address above:

Birthdate: Age:

Referred by: Below, please indicate name of referral source and reason for referral

II. Personal History:

_single __married __living together __separated __divorced __widowed

Number of years married, separated, divorced, or widowed:

Indicate if parents are alive or deceased, their ages, and their marital status:

Do you have any relatives with mental illness? If so, please indicate who and the nature of the illness:

Highest grade completed:

Current employer/Job Title:

Profession, occupation or grade regardless of employment status:

Pregnancies

1. How many times have you been pregnant (including current pregnancy if currently pregnant):

2. How many miscarriages or other kinds of losses have you had if any (and at what week gestation):

3. Please explain any pregnancy complications if applicable:

4. How many living children? How old are they?

5. Have you ever had infertility treatments? If yes, please explain what the treatments were and why you received them.

6. If pregnant, do you feel as if feelings if sadness and/or anxiety are preventing you from enjoying your pregnancy? If yes, please explain:

7. If experiencing fertility problems, please briefly describe the impact this has had on how you feel about yourself and others, your relationships, and your everyday functioning?

III. Medication History:

Name of medication: for medical and psychiatric conditions	Prescribed by	Prescribed for what condition and symptom?

IV. Current psychiatric condition and treatment

Please describe your major complaint(s), symptom(s), or problem(s):

Are you currently engaged in psychotherapy or counseling? If, yes, please explain: Please note that to protect the integrity of the therapist-patient relationship professional ethics codes discourage me from providing services to you if you are currently in a similar treatment with another provider.

Have you gained or lost a significant amount of weight in the past year?

Have you experienced significant changes in your sleep patterns or appetite?

Please indicate anything else which may be significant regarding your physical or emotional health:

Have you had any of the following during the same 2 week period, representing a change from a previous period?

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful): □ No □ Yes

2. Markedly diminished interest in pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others): □ No □ Yes

3. Significant weight loss when not dieting or weight gain (e.g., change of more than 5% body weight in a month), or decrease or increase in appetite nearly every day : □ No □ Yes

4. Insomnia or hypersomnia nearly every day: □ No □ Yes

5. Psychomotor agitation or retardation nearly every day: □ No □ Yes

6. Fatigue or loss of energy nearly every day: No Yes

7. Feelings of worthlessness or excessive or inappropriate guilt nearly every day: No Yes

8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either subjective account or as observed by others): No Yes

9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide: If yes, please explain: No Yes

10. If a new mother, have any of the above symptoms (#1-9) first arose within 4 weeks of giving birth? No Yes

11. If a new mother, have your experienced thought of harming your baby: No Yes

12. Have you experienced excessive worry or anxiety on most days for the past 6 months? No Yes

13. Is it difficult to control this anxiety or worry? No Yes

14. During this 6 month period have you experienced any of the following symptoms:
    - Restlessness: No Yes
    - Fatigue: No Yes
    - Difficulty Concentrating: No Yes
    - Irritability: No Yes
    - Insomnia: No Yes
    - Muscle tension: No Yes

15. Have you ever experienced a panic attack? If so, when. No Yes

V. **Psychiatric History:**

Age of first contact with mental health professional? For what condition and symptoms?

Have you ever been hospitalized for a psychological condition (dates, hospital name, and reason for hospitalization):

History of suicide attempts/gestures, deliberate self-injury and other self-destructive behaviors:

Please describe all previous outpatient psychotherapy or counseling (when, for how long, reasons for seeking treatment, name of doctor):

VI. **Relationships in your family of origin.** Please describe the following:

1. Your parents' relationship with each other:

2. Your relationship with each parent and with other adults present:

3. Your parents' physical health problems, drug or alcohol use, and mental or emotional difficulties:

4. Your relationship with your brothers and sisters, in the past and present:

VIII. Present relationships

1. How do you get along with your present spouse or partner?

2. How do you get along with your children if any?

3. Your important friends, past and present:

Good parts of relationship:

Bad parts of relationship:

IX. Chemical use
1. Have you ever felt the need to cut down on your drinking? □ No □ Yes

2. Have you ever felt annoyed by criticism of your drinking? □ No □ Yes

3. Have you ever felt guilty about your drinking? □ No □ Yes

4. Have you ever taken a morning "eye-opener"? □ No □ Yes

5. How much beer, wine, or hard liquor do you consume each week,on the average?
____

6. Are there times when you drink to unconsciousness, or run out of money as a result of drinking?
____

7. How much tobacco do you smoke or chew each week? _________________

8. Have you ever used inhalants ("huffing") such as glue, gasoline, or paint thinner? □ No □ Yes
If yes, which and when?
____

X. Legal history
1. Are you presently suing anyone or thinking of suing anyone? □ No □ Yes If yes, please explain:

2. Is your reason for coming to see me related to an accident or injury? □No □Yes If yes, please explain:

3. Are you required by a court, the police, or a probation/parole officer to have this appointment? □ No
□ Yes If yes, please explain:

4. List all the contacts with the police, courts, and jails/prisons you have had. Include all open charges and pending ones. Include dates, charges, jurisdiction (F = federal, S = state,Co = county, Ci = city), type of sentence you served or have to serve (AR =

accelerated or alternate resolution,CS = community service, F = fine, I = incarceration, Pr = probation, Po = parole, O = other, R = restitution), and probation/parole information.

____
Printed Name

____
Signature and Date

____
Legal Guardian if under 18 and date