

EMORY WOMEN'S MENTAL HEALTH PROGRAM INTAKE PACKET

Thank you for taking the time to fill out these forms. Please answer the questions to the best of your ability. The information we collect will be helpful to your clinician and provide the cornerstone for future preventative studies. The information gathered here will be kept strictly confidential.

NAME: _____ **DATE:** ____/____/____ **AGE:** _____
ADDRESS: _____

PHONE NOS. - HOME: _____ **CELL:** _____ **WORK:** _____
EMAIL: _____ **SSN:** _____

General Information

♦ MARITAL STATUS

Never married / living alone
Never married / living with partner ____ (how long)
Married ____ (how long) ____ (number of times)
Divorced
Widowed

♦ RACIAL BACKGROUND

African American / African / Black
Asian / Indian
Caucasian
Native American / Alaska Native
Pacific Islander
More than one race
Other _____

♦ PARTNER'S RACIAL BACKGROUND

African American / African / Black
Asian / Indian
Caucasian
Native American / Alaska Native
Pacific Islander
More than one race
Other _____

♦ ETHNICITY

Hispanic Not Hispanic

♦ PARTNER'S ETHNICITY

Hispanic Not Hispanic

♦ YOUR EDUCATION

Did not finish high school
High school graduate/GED
Completed trade school
Some college
Bachelor's degree
Some graduate school
Masters degree
Doctoral degree (PhD, MD, JD, EdD, etc)

♦ PARTNER'S EDUCATION

Did not finish high school
High school graduate/GED
Completed trade school
Some college
Bachelor's degree
Some graduate school
Masters degree
Doctoral degree (PhD, MD, JD, EdD, etc)

♦ YOUR OCCUPATION

♦ PARTNER'S OCCUPATION

♦ DURING THE LAST MONTH, WHAT WAS YOUR LEVEL OF FUNCTION AT WORK?

Working full-time at a job
Working full-time running household
Working part-time
School/college full-time
School/college part-time

Unemployed but able to work
Doing volunteer work
Unable to work
Other (describe) _____

♦ **YOUR CURRENT LIVING SITUATION**

- Living with your husband
- Living with your partner / significant other
- Living as a single parent with your child(ren)
- Living on your own (alone or with roommate)

- Living with your family of origin (parents, etc)
- Living in a group home
- Homeless
- Other (describe) _____

♦ **YOUR BIRTH DATE** ____/____/____

♦ **YOUR HEIGHT** (ft., in.) _____

♦ **YOUR PRE-PREGNANCY WEIGHT** (lbs) _____

♦ **RELIGIOUS AFFILIATION** _____

Gynecological History

♦ **YOUR OB/GYN'S NAME / ADDRESS / PHONE**

♦ **HOW OLD WERE YOU WHEN YOU HAD YOUR FIRST MENSTRUAL PERIOD?** _____

♦ **HOW MUCH PAIN DO YOU USUALLY HAVE WITH YOUR PERIODS?**

- No Pain
- Mild cramps or infrequent pain, medication seldom needed
- Moderate cramps, medication usually needed
- Severe cramps, medication and bed rest needed

♦ **HOW REGULAR IS YOUR MENSTRUAL CYCLE?**

- Regular _____ (average number of days per cycle)
- Irregular

♦ **DO YOU HAVE A HISTORY OF:**

- | | | |
|-----------|--------------------------|---------------------|
| PMS | Urinary Tract Infections | Gonorrhea |
| Chlamydia | Syphilis | Abnormal Pap Smears |

♦ **DO YOU OR THE BABY'S FATHER HAVE A HISTORY OF:**

- | | | | |
|--------|-----|-------------|-------------|
| Herpes | HIV | Hepatitis B | Hepatitis C |
|--------|-----|-------------|-------------|

♦ **HAVE YOUR PERIODS EVER STOPPED TEMPORARILY?** YES NO

If yes, mark which event caused your periods to stop and how long:

- Sudden weight loss
- Hormonal Medication [Lupron (Luprolide), Danocrine (Danzol), Synarel (Nafareline), Depo-provera]
- Low body fat
- Chemotherapy/radiation treatments
- Unexplained
- Other _____

♦ **HAVE YOU EVER BEEN TOLD THAT YOU HAD ANY OF THE FOLLOWING CONDITIONS?**

- Sexually Transmitted Disease
- Endometriosis
- Polycystic Ovaries
- Pelvic Inflammatory Disease
- Fibroid Uterus
- Fibrocystic Breast Disease
- Breast Cancer

- ♦ **ARE YOU CURRENTLY SEXUALLY ACTIVE?** YES NO
 - ♦ **WHAT KIND OF BIRTH CONTROL ARE/WERE YOU CURRENTLY USING?** _____
 - ♦ **WHAT BIRTH CONTROL METHODS HAVE YOU USED IN THE PAST AND WHEN?**
 METHOD: YEARS:
-
-

Genetic History

I WILL BE AGE 35 OR OLDER AT THE TIME OF DELIVERY? YES NO
 I HAVE HAD 3 OR MORE MISCARRIAGES. YES NO
 I HAVE HAD A MISCARRIAGE WORKUP DONE. YES NO

| | | |
|------------------------------------|---------------------|----------|
| I HAVE BEEN PREVIOUSLY TESTED FOR: | If tested – Results | |
| Sickle Cell Disease | Normal | Abnormal |
| Tay-Sachs | Normal | Abnormal |
| B-thalassemia | Normal | Abnormal |
| A-thalassemia | Normal | Abnormal |
| Cystic Fibrosis | Normal | Abnormal |

If any of these tests were positive please describe: _____

IS THERE A FAMILY HISTORY OF (Patient, Father of the baby, or a close relative in either family)

| | | | | | | | | |
|---------------|-----|----|---------------------|-----|----|---------------------|-----|----|
| Thalassemia | Yes | No | Sickle Cell Disease | Yes | No | Cystic Fibrosis | Yes | No |
| Down Syndrome | Yes | No | Hemophilia | Yes | No | Huntington's Chorea | Yes | No |
| Tay-Sachs | Yes | No | Muscular Dystrophy | Yes | No | Neural Tube Defects | Yes | No |

Other Chromosomal anomalies not listed above? _____
 Mental Retardation associated with Fragile X? Yes No
 Birth defects or inherited genetic disorders not listed above? _____

Obstetrical History

- ♦ **HOW MANY TIMES HAVE YOU BEEN PREGNANT?** (including current pregnancy) _____
- ♦ **HOW MANY FULL-TERM DELIVERIES?** (≥ 37 completed weeks) _____
- ♦ **HOW MANY PRETERM DELIVERIES?** (≥ 20 TO < 37 completed weeks) _____
- ♦ **HOW MANY MISCARRIAGES?** (pregnancy loss before 20 completed weeks) _____
- ♦ **HOW MANY ABORTIONS HAVE YOU HAD?** _____
- ♦ **HOW MANY LIVING CHILDREN DO YOU HAVE?** _____
 If one of your children has died, please explain the circumstances: _____
- ♦ **HOW MANY MULTIPLE GESTATIONS AND BIRTHS HAVE YOU HAD?** _____
- ♦ **DID YOU EVER TRY FOR > 2 YEARS TO GET PREGNANT OR HAVE REPEATED PROBLEMS CARRYING A PREGNANCY?** YES NO

• **HAVE YOU EVER USED FERTILITY MEDICATIONS SUCH AS CLOMID OR PERGANOL or IN VITRO FERTILIZATION?** YES NO
WHAT WAS THE NAME OF THE MEDICATION? _____

Please Include: Abortions, Stillborns, Miscarriages and Ectopic Pregnancies

PAST PREGNANCIES

| Date of Birth | Name of Child | Gender | Weight | Length of Labor | Weeks | Type | Anesthesia | Complications | Preterm Labor |
|---------------|---------------|--------|--------|-----------------|-------|------|------------|---------------|---------------|
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |

Type: i.e. Vaginal, C/S, Forceps or Vacuum

Anesthesia: i.e. Epidural, Local, General, Demerol

Complications: i.e. Diabetes, Bleeding, Hypertension

Current /Most Recent Pregnancy

- **WAS THIS PREGNANCY PLANNED?** YES NO
- **WAS THIS PREGNANCY DESIRED?** YES NO MIXED FEELINGS
- **WHAT WAS THE FIRST DAY OF YOUR LAST MENTRUAL PERIOD?** ____/____/____
- **WHAT IS YOUR ESTIMATED DATE OF DELIVERY?** ____/____/____
- **WAS THIS PREGNANCY A RESULT OF:**
 - Fertility Medications Such as CLOMID OR PERGANOL?** YES NO
 - IVF (In Vitro Fertilization)** YES NO
 - Other Reproductive Technology** YES NO **List:** _____
- **WHAT WEEK OF YOUR PREGNANCY DID YOU BEGIN FEELING DOWN?** _____
OR WHAT WEEK POSTPARTUM DID YOU BEGIN FEELING DOWN? _____
- **PLEASE LIST ANY MEDICATIONS (OVER THE COUNTER & PRESCRIPTIONS) TAKEN DURING YOUR PREGNANCY.** _____
- **WHEN DID YOU START YOU PRENATAL VITAMIN?** _____
- **DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING IN YOUR CURRENT PREGNANCY?**
 - Nausea Frequent Urination Low amniotic fluid
 - Excessive Vomiting Gestational Diabetes Edema (water retention)
 - Headaches Preterm Labor Preeclampsia
 - Placenta Previa

Delivery & Postpartum

If you are currently pregnant, please skip this section.

- **BABY'S DATE OF BIRTH** ____/____/____
- **BABY'S SEX:** MALE FEMALE
- **BIRTH WEIGHT** _____
- **LENGTH** _____
- **HEAD CIRCUMFERENCE** _____

- ♦ **APGAR SCORES:** _____ & _____
- ♦ **PLEASE LIST ANY DELIVERY COMPLICATIONS.** _____
- ♦ **HOW LONG WERE YOU HOSPITALIZED FOR DELIVERY?** _____
- ♦ **WHAT METHODS HAVE YOU/ARE YOU USING TO FEED YOUR BABY?**

| | |
|----------------|---------|
| METHOD: | MONTHS: |
| Bottle/Formula | _____ |
| Breastfeeding | _____ |
| Both | _____ |
| Other: _____ | _____ |
- ♦ **PEDIATRICIAN'S NAME AND ADDRESS:** _____
- ♦ **HAS YOUR MENSTRUAL CYCLE RETURNED?** YES NO
- ♦ **DID YOU HAVE ANY HELP WITH THE BABY AFTER THE HOSPITAL?**
NO YES, WHO? _____

Psychiatric History

- ♦ **PREVIOUS SUICIDE ATTEMPTS OR SELF-INJURY?** LIST NUMBER OF TIMES, METHODS, DATES:

- ♦ **PREVIOUS HOMICIDE OR VIOLENCE (INCLUDING CHILDREN)?**

- ♦ **PREVIOUS OUTPATIENT PSYCHIATRIC TREATMENT? WHERE AND WHEN? FOR WHAT PERIOD OF TIME?**

- ♦ **PREVIOUS PSYCHIATRIC HOSPITALIZATIONS? WHERE AND WHEN? FOR WHAT PERIOD OF TIME?**

- ♦ **HAS A PROFESSIONAL, FRIEND, OR FAMILY MEMBER EVER SAID YOU WERE DEPRESSED OR HAD ANXIETY?** NO YES, WHO? _____
- ♦ **HAVE YOU EVER SOUGHT TREATMENT FOR DEPRESSION OR ANXIETY?** YES NO
- ♦ **HAVE YOU EVER HAD PSYCHOTHERAPY AS YOUR MAIN TREATMENT?** YES NO
- ♦ **HAVE YOU EVER SOUGHT TREATMENT FOR ANY OTHER PSYCHIATRIC CONDITION?**
YES NO IF YES, WHAT? _____
- ♦ **HAVE YOU EVER BEEN TOLD BY A CLINICIAN THAT YOU HAVE ANY OF THE FOLLOWING:**

| | |
|-------------------------------------|------------------------------------|
| Major Depression | Schizophrenia |
| Postpartum Depression | Schizoaffective Disorder |
| Dysthymic Disorder | Any Other Psychotic Disorder |
| PMS / Premenstrual Depression | |
| Bipolar Disorder / Manic Depression | Anorexia Nervosa |
| | Bulimia Nervosa |
| Generalized Anxiety Disorder | Any Other Eating Disorder |
| Panic Disorder | |
| Obsessive Compulsive Disorder | Alcohol Abuse or Dependence |
| Social Anxiety Disorder | Cocaine Abuse or Dependence |
| Posttraumatic Stress Disorder | Any Other Substance Abuse Disorder |
| Any Other Anxiety Disorder | |
| | Migraine Headaches |
| Other, Please Specify _____ | |

♦ **WHICH OF THE FOLLOWING PSYCHIATRIC MEDICINES HAVE YOU TAKEN IN THE PAST?**

| Medication | Year(s) Taken 19__ to 20__ | Medication | Year(s) Taken 19__ to 20__ |
|-------------------------------------|----------------------------|---|----------------------------|
| Antidepressants | | Anti-Anxiety Medications | |
| Anafranil (clomipramine) | | Atarax / Vistaril (hydroxyzine) | |
| Celexa (citalopram) | | Ativan (lorazepam) | |
| Desyrel (trazodone) | | Buspar (buspirone) | |
| Effexor (venlafaxine) | | Klonopin (clonazepam) | |
| Elavil (amitriptyline) | | Librium (chlordiazepoxide) | |
| Lexapro (escitalopram) | | Valium (diazepam) | |
| Luvox (fluvoxamine) | | Xanax (alprazolam) | |
| Norpramine (desipramine) | | Other Anti-Anxiety (Name _____) | |
| Pamelor (nortriptyline) | | Mood Stabilizers / Anti-Epilepsy Drugs | |
| Paxil (paroxetine) | | Depakote (valproate) | |
| Prozac / Sarafem (fluoxetine) | | Dilantin (phenytoin) | |
| Remeron (mirtazapine) | | Eskalith / Lithobid (lithium) | |
| Serzone (nefazodone) | | Keppra (levetiracetam) | |
| Sinequan (doxepin) | | Lamictal (lamotrigine) | |
| Tofranil (imipramine) | | Neurontin (gabapentin) | |
| Wellbutrin / Zyban (bupropion) | | Tegretol / Carbatrol (carbamazepine) | |
| Zoloft (sertraline) | | Topamax (topiramate) | |
| Other Antidepressant (Name _____) | | Trileptal (oxcarbazepine) | |
| Antipsychotics | | Stimulants / ADHD Medications | |
| Abilify (aripiprazole) | | Other Mood Stabilizer / AED (Name _____) | |
| Clozaril (clozapine) | | Adderall (amphetamine mixture) | |
| Geodon (ziprasidone) | | Cylert (pemoline) | |
| Haldol (haloperidol) | | Dexedrine (dextroamphetamine) | |
| Risperdal (risperidone) | | Meridia (sibutramine) | |
| Seroquel (quetiapine) | | Provigil (modafinil) | |
| Zyprexa (olanzapine) | | Ritalin / Concerta / Metadate (methylphenidate) | |
| Other Antipsychotic (Name _____) | | Other Stimulant (Name _____) | |
| Sleep Medication | | | |
| Ambien (zolpidem) | | | |
| Lunesta () | | | |
| ProSom (estazolam) | | | |
| Restoril (temazepam) | | | |
| Sonata (zaleplon) | | | |
| Other Sleep Medication (Name _____) | | | |

Drug & Alcohol History

♦ **CURRENT USE OR USE IN PREGNANCY?** YES__ NO__

♦ **PAST USE OF DRUGS & ALCOHOL?** YES__ NO__

IF YES, WHICH OF THE FOLLOWING:

| | | | | |
|------------------|----------------------------------|-------------------------|----------------------|-----------------|
| Drug Name | Age of 1st Use | Current Amt/Freq | Peak Amt/Freq | Last Use |
|------------------|----------------------------------|-------------------------|----------------------|-----------------|

MARIJUANA _____
REEFER, HASHISH, BLUNTS, JOINTS, WEED, GRASS

COCAINE _____
POWDER, FREEBASED, CRACK, IN JOINT (GEEK JOINTS) OR CIGARETTE, IV

ALCOHOL _____
WINE, BEER, LIQUOR

SEDATIVES _____
BARBITURATES, BENZODIAZEPINES, QUAAALUDES, DOWNER'S

HALLUCINOGENS _____
LSD, PCP, ACID

AMPHETAMINES _____
 UPPERS, SPEED, CRANK, ICE, 8-BALLS
 NARCOTICS _____
 HEROIN, PERCODAN, DEMORAL, DILAUDID, METHADONE
 INHALANTS _____
 GASOLINE, GLUE, PAINT THINNER, WHITE-OUT, HUFFING
 TOBACCO _____

♦ **TREATMENT FOR DRUG OR ALCOHOL ABUSE:** LIST LOCATIONS, DATES OF TREATMENT, DURATION.

INPATIENT DETOX _____

LONG-TERM RESIDENTIAL _____

OUTPATIENT _____

NA/AA MEETINGS _____

♦ **LONGEST PERIOD OF SOBRIETY:** _____

♦ **LEGAL PROBLEMS RELATED TO DRUG/ALCOHOL USE:** _____

♦ **WITHDRAWAL SYMPTOMS / MEDICAL PROBLEMS FROM DRUG/ALCOHOL USE:** _____

♦ **LOSS OF JOB, CHILD CUSTODY, RELATIONSHIP DUE TO DRUG/ALCOHOL USE:** _____

Family Psychiatric History

♦ **HAVE ANY OF THE FOLLOWING BEEN DIAGNOSED IN YOUR FAMILY?**

| | | | | | | | | |
|-------------------------------------|------|--------|--------|---------------------|--------------------|------------------|-------|---------|
| MAJOR DEPRESSION | NONE | MOTHER | FATHER | SIBLING: BRO/SIS | CHILD: SON/DAU. | GRAND- PARENT | OTHER | UNKNOWN |
| POSTPARTUM DEPRESSION | NONE | MOTHER | | SIBLING: SISTER | CHILD: DAU | GRAND- PARENT | OTHER | UNKNOWN |
| BIPOLAR DISORDER / MANIC DEPRESSION | NONE | MOTHER | FATHER | SIBLING: BRO/SIS | CHILD: SON/DAU. | GRAND- PARENT | OTHER | UNKNOWN |
| GENERALIZED ANXIETY DISORDER | NONE | MOTHER | FATHER | SIBLING: BRO/SIS | CHILD: SON/DAU. | GRAND- PARENT | OTHER | UNKNOWN |
| PANIC DISORDER | NONE | MOTHER | FATHER | SIBLING: BRO/SIS | CHILD: SON/DAU. | GRAND- PARENT | OTHER | UNKNOWN |
| OBSESSIVE COMPULSIVE DISORDER | NONE | MOTHER | FATHER | SIBLING: BRO/SIS | CHILD: SON/DAU. | GRAND- PARENT | OTHER | UNKNOWN |
| SOCIAL ANXIETY DISORDER | NONE | MOTHER | FATHER | SIBLING: BRO/SIS | CHILD: SON/DAU. | GRAND- PARENT | OTHER | UNKNOWN |
| POSTTRAUMATIC STRESS DISORDER | NONE | MOTHER | FATHER | SIBLING: BRO/SIS | CHILD: SON/DAU. | GRAND- PARENT | OTHER | UNKNOWN |
| SCHIZOPHRENIA | NONE | MOTHER | FATHER | SIBLING: BRO/SIS | CHILD: SON/DAU. | GRAND- PARENT | OTHER | UNKNOWN |
| SCHIZOAFFECTIVE DISORDER | NONE | MOTHER | FATHER | SIBLING: BRO/SIS | CHILD: SON/DAU. | GRAND- PARENT | OTHER | UNKNOWN |
| EATING DISORDER | NONE | MOTHER | FATHER | SIBLING: BRO/SIS | CHILD: SON/DAU. | GRAND- PARENT | OTHER | UNKNOWN |
| ALCOHOL ABUSE / DEPENDENCE | NONE | MOTHER | FATHER | SIBLING: BRO/SIS | CHILD: SON/DAU. | GRAND- PARENT | OTHER | UNKNOWN |
| COCAINE ABUSE / DEPENDENCE | NONE | MOTHER | FATHER | SIBLING: BRO/SIS | CHILD: SON/DAU. | GRAND- PARENT | OTHER | UNKNOWN |
| ANY OTHER SUBSTANCE ABUSE | NONE | MOTHER | FATHER | SIBLING: BRO/SIS | CHILD: SON/DAU. | GRAND- PARENT | OTHER | UNKNOWN |
| ATTENTION DEFICIT/HYPERACTIVITY D/O | NONE | MOTHER | FATHER | SIBLING: BRO/SIS | CHILD: SON/DAU. | GRAND- PARENT | OTHER | UNKNOWN |
| OTHER MENTAL ILLNESS (_____) | NONE | MOTHER | FATHER | SIBLING: BRO/SIS | CHILD: SON/DAU. | GRAND- PARENT | OTHER | UNKNOWN |

Medical History

♦ **DO YOU HAVE ANY ALLERGIES?**

YES NO

Reaction: _____

♦ **ARE YOU CURRENTLY TAKING ANY MEDICATION FOR ALLERGIES?** YES NO

♦ **PAST OR CURRENT MEDICAL PROBLEMS (Please check ALL that apply to you.)**

| | | | | |
|---|--|-------------------------------------|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> G.I. Illness | <input type="checkbox"/> Seizures | <input type="checkbox"/> Headaches | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rh Disease | <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> UTI (chronic) |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Lupus | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Group B Strep |

♦ **DO YOU SMOKE?** YES NO How many cigarettes per day? _____

♦ **HOW MANY CUPS OF CAFFEINATED BEVERAGES DO YOU DRINK PER DAY?** _____

♦ **DO YOU WEAR SEATBELTS?** YES NO

Current Status

♦ **ARE YOU CURRENTLY SEEING A PSYCHIATRIST/THERAPIST? WHO? WHERE?**

♦ **WHAT PSYCHIATRIC MEDICATIONS ARE YOU CURRENTLY TAKING? AT WHAT DOSE?**

♦ **LIST ALL PRESCRIPTION MEDICINES, OVER-THE-COUNTER MEDICINES, VITAMINS, & HERBS YOU HAVE TAKEN IN THE LAST MONTH:** _____

♦ **MEDICATION ALLERGIES:** _____

What was the reaction? _____

When did this occur (age or year)? _____

♦ **DO YOU HAVE OTHER CHILDREN? WITH WHOM DO THEY LIVE? EVER LOST CUSTODY?**

♦ **CURRENT OR PAST CHILD PROTECTIVE SERVICES (DFACS) INVOLVEMENT?**

♦ **ARE YOU CURRENTLY HAVING PROBLEMS WITH ANY OF THE FOLLOWING SYMPTOMS?**

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Sad Mood | <input type="checkbox"/> Suicidal Ideation | <input type="checkbox"/> Agoraphobia | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Tearfulness | <input type="checkbox"/> Homicidal Ideation | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Hyperactive/Impulsive |
| <input type="checkbox"/> No Pleasure | <input type="checkbox"/> Low Self-esteem | <input type="checkbox"/> Flashbacks | <input type="checkbox"/> Confused Thinking |
| <input type="checkbox"/> No Energy | <input type="checkbox"/> Poor Concentration | <input type="checkbox"/> Obsessions | <input type="checkbox"/> Disorganization |
| <input type="checkbox"/> Sleep Disturbance | <input type="checkbox"/> Anxiety/Worry | <input type="checkbox"/> Compulsions | <input type="checkbox"/> Hallucinations |
| <input type="checkbox"/> Appetite Disturbance | <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Elation/Mania | <input type="checkbox"/> Delusion |

♦ **ANY OTHER SPECIAL PROBLEMS OR STRESSES CURRENTLY?**

Cancellation Policy

Since the majority of our patients have children and very busy schedules, we understand that occasionally it may be necessary to cancel an appointment. We do not bill for cancellations as we typically have a waiting list, but we ask that you call at least 24 hours prior to your appointment to cancel. If you do not cancel an appointment within 24 hours, it is considered a "missed" appointment. It is the policy of the Emory Women's Mental Health Program to terminate your care after two missed appointments.

I have read and understand the cancellation policy of the Emory Women's Mental Health Program.

Signature

____/____/____
Date