The Postpartum Stress Center

PPSC PHONE CONSULTATION

☐ Date: _____

NAME: Home Phone:

Address:

City: State: Zip:

Other Phone: Work: Cell:

Age: _____

Marital status: Duration: First Marriage?

Partner's Name:

How referred to us:

Current work status: ☐ SAHM ☐ Full-time ☐ Part-time ☐ Maternity leave

If working outside the home, what is your occupation?

_____ ☐ Days ☐ Weeks ☐ Months POSPTARTUM

PPD SYMPTOMS / STATUS

1) What symptoms are you currently experiencing?

2) When did you first start feeling bad?

3) How have the symptoms changed since then

☐ Much better ☐ Somewhat better ☐ Stayed the same ☐ A bit worse ☐ Much worse

4)Have you been diagnosed with PPD by a healthcare practitioner?

☐ Yes If Yes, who?
☐ No

5) Are you currently in therapy?

☐ Yes If Yes, does this feel like a good place for you to be? Why? / Why not?
☐ No

6) Are you currently taking medication for depression?

☐ Yes If Yes, what medication(s)? What dose? How long?
☐ No

7) Are you taking any other medication either OTC or prescribed?

☐ Yes If Yes, please list:
☐ No

8) Are you taking any herbal supplements?

☐ Yes If Yes, please list:
☐ No

9) Are you taking birth control pills?

☐ Yes ☐ No

10) Have you recently had a physical?

☐ Yes ☐ No

Have you had your thyroid checked?

☐ Yes ☐ No

11) What are you experiencing that is the most worrisome to you?

12) To what degree does your anxiety interfere with your life right now?

0 1 2 3 4 5 6 7 8 9 10
none somewhat moderately very much

13) To what degree does your depression interfere in your life right now?

0 1 2 3 4 5 6 7 8 9 10
none somewhat moderately very much

14) To what degree are you are worried about the way you are feeling now?

0 1 2 3 4 5 6 7 8 9 10
none somewhat moderately very much

15) Is sleeping a problem?

0 1 2 3 4 5 6 7 8 9 10
none somewhat moderately very much

16) How many hours of sleep do you average a night?

17) Are you able to sleep when your baby sleeps?

☐ Yes
☐ No If No, what keeps you up?

18) Have you experienced a change in your appetite?

☐ Yes If Yes, please describe:
☐ No

19) Are you having thoughts that are scaring you?

0 1 2 3 4 5 6 7 8 9 10
none somewhat moderately very much

20) Are you having any thoughts of hurting yourself?

0 1 2 3 4 5 6 7 8 9 10
none somewhat moderately very much

21) Is your partner or family worried about you?

0 1 2 3 4 5 6 7 8 9 10
none somewhat moderately very much

22) Have you experienced any of the following in the past year?

☐ Move to new house or city

☐ Job change or loss (you / partner)

☐ Financial problems

☐ Loss of loved one

☐ Medical problems or illness (you / family member)

☐ Marital stress

☐ Other: _____

HISTORY

☐ Yes ☐ No Is this your first pregnancy? If no, please list children and ages:

☐ Yes ☐ No Did you have fertility problems? If yes, please provide pertinent details:

☐ Yes ☐ No Have you ever had an abortion? If yes, please explain how you felt about this:

☐ Yes ☐ No Have you experienced a miscarriage, infant loss, or other pregnancy-related bereavement? If

yes, please explain:

☐ Yes ☐ No Do you have a history of PMS? If Yes, ☐ Severe ☐ Moderate ☐ Mild

☐ Yes ☐ No Have you experienced depression in the past? If yes, did you receive treatment? Please explain:

☐ Yes ☐ No Have you experienced PPD with previous births? If yes, please describe treatment course:

☐ Yes ☐ No Has anyone in your family suffered from depression? If yes, please describe:

☐ Yes ☐ No Have you ever had an eating disorder? If yes, did you receive treatment for this? Please explain:

☐ Yes ☐ No Is there any history of alcohol or drug addiction in your family? If yes, explain:

☐ Yes ☐ No Do you have any history of addictive behavior? If yes, please explain:

☐ Yes ☐ No As far as you know, have you ever experienced an abusive relationship? If yes, please explain:

PREGNANCY

23) Was this pregnancy planned?

☐ Yes

☐ No If No, how did you feel when you discovered you were pregnant?

24) How did you feel physically during your pregnancy? Please describe:

25) How did you feel emotionally during your pregnancy? Please describe:

26) Did you receive any counseling or medication treatment during this pregnancy?

☐ Yes If Yes, please describe:

☐ No

27) Did you experience any complications during pregnancy and/or delivery?

☐ Yes If Yes, please describe:

☐ No

28) How did you perceive your delivery and post-delivery hospital experience to be?

☐ Uneventful ☐ Somewhat disappointing ☐ Not what I expected ☐ Problematic (please explain):

29) What expectations did you have during your pregnancy that were **not** met after you had your baby?

<u>BABY</u>

30) Name, gender and age of baby:

31) Does your baby have any medical or physical complications?

☐ Yes If yes, please describe:

☐ No

32) How would you describe your baby's disposition?

33) How do you feel when you hear your baby cry?

34) Are you able to enjoy your baby?

☐ Yes, most of the time ☐ Some of the time ☐ Not as much as I'd like ☐ I don't enjoy my baby at all

How do you feel about this?:

35) Did you expect to feel this way about your baby?

☐ Yes ☐ No

36) Are you experiencing an increase in anxious or obsessive thoughts related to your baby?

0 1 2 3 4 5 6 7 8 9 10
none somewhat moderately very much

37) Do you find you are preoccupied with the baby's well-being?

0 1 2 3 4 5 6 7 8 9 10
none somewhat moderately very much

38) Is your baby experiencing any difficulties?

☐ Yes If yes, please describe:
☐ No

39) How is your baby sleeping now?

☐ Fine, no problems ☐ Intermittent problems ☐ Not sleeping well at all

40) Are you concerned about your attachment to your baby?

☐ Yes If Yes, please explain:
☐ No

41) How are you feeding your baby?

☐ Breastfeeding ☐ Bottlefeeding ☐ Supplementing ☐ Solids

42) If breastfeeding, have you recently changed modes of feeding?

☐ Weaning ☐ Stopped nursing ☐ Planning to wean ☐ Not applicable

<u>SUPPORT</u>

43) How would you describe your relationship with your partner at this time?

44) How much practical support (household) do you get from your partner?

0 1 2 3 4 5 6 7 8 9 10
not enough enough very much

How does this make you feel?

45) How much emotional support to you get from your partner?

0 1 2 3 4 5 6 7 8 9 10
not enough enough very much

How does this make you feel?

46) How has the baby affected your relationship with your partner?

47) How do you think your partner is feeling?

- About you?
- About your baby?
- About himself?
- About the situation?

48) What would you change, if you could, regarding the support you are receiving from your partner?

49) What resources does your partner have for *his* support?

50) Do you or your partner engage in any activity that you feel is self-destructive or making things worse?

51) If there were one thing you could ask of your partner now, what would it be?

52) Do you have other sources of support available? Family? Friends? Please explain:

53) What do you consider to be your greatest personal strength at this time?

54) What do you consider to be your most limiting personal weakness at this time?

55) Is there anything about your current treatment that you are uncomfortable with? ☐ No treatment at this time

56) In what ways do you think your symptoms have improved since you first started feeling bad or since treatment began?
Please be specific:

57) In what ways do you think your symptoms have not improved since treatment began?
Please be specific:

58) WHAT IS YOUR BIGGEST CONCERN AND YOUR PRIMARY REASON FOR THIS CONSULTAION?

59) What questions do you want to make sure we cover during this consultation?

a)

b)

c)

60) Is there anything we have not covered here that you would like us to know?