

Well-being Health History

This helps us know how best to support you and understand if you might be at greater risk of struggling during pregnancy or the postpartum period (the year after childbirth), or suffering from a maternal mental health condition.

We are here to help.

Are you aware of a **personal or family history of mental health challenges**?

If so, let us know who? (circle all that apply):

SELF MOM DAD SISTER(S) BROTHER(S) GRANDMOTHER(S) GRANDFATHER(S)
AUNT(S) UNCLE(S)

If you've circled any of the above, please **share which disorders or challenges you or a family member experienced** on the line below.

These could include a range of challenges, such as:

Depression WHO: _____

Anxiety WHO: _____

OCD WHO: _____

Intrusive unwanted thoughts WHO: _____

Eating disorder WHO: _____

Bipolar disorder (I or II) WHO: _____

Personality disorders (like
borderline personality disorder) WHO: _____

Non-Suicidal Self-Harm (like cutting) WHO: _____

PTSD WHO: _____

Severe Mental Illness WHO: _____

(like schizophrenia)

Substance use disorder WHO: _____

(such as high alcohol
or cannabis intake, opioid RX
or illicit drug use)

Other WHO: _____

Please share anything else that would be helpful for us to know:

If **you** have experienced one or more of the challenges or conditions above, **have you received treatment before?** If so, **please share the type of treatment**, such as seeing a therapist or trying a prescription drug like Zoloft. Leave blank if you haven't had treatment for the disorder/challenge.

Depression Treatment: _____ Current Previous

Anxiety Treatment: _____ Current Previous

OCD Treatment: _____ Current Previous

Intrusive unwanted thoughts Treatment: _____ Current Previous
Eating disorder Treatment: _____ Current Previous
Bipolar disorder (I or II) Treatment: _____ Current Previous
Personality disorders (like
borderline personality disorder) Treatment: _____ Current Previous
Non-Suicidal Self-Harm (like cutting) Treatment: _____ Current Previous
PTSD Treatment: _____ Current Previous
Severe Mental Illness Treatment: _____ Current Previous

(like schizophrenia)
Substance use challenges Treatment: _____ Current Previous
(such as high alcohol
or cannabis intake
or illicit drug use)
Other _____ Treatment: _____ Current Previous

Are you currently under the care of a psychiatrist (who prescribes drug treatments for any of the above) or therapist? If so please provide their name(s) (and phone number if you have it):

Fertility History

Did you have difficulty conceiving?

Have you received infertility treatment? YES NO

If so, what type of treatment and for how long?

Sleep

Do you have a history of sleep difficulties outside of pregnancy or the postpartum? YES NO

Please explain:

Breastfeeding History and Hopes

Have you tried breastfeeding in the past? YES NO NA

If so, how did it go?

Do you plan to breastfeed with this pregnancy? YES NO Unsure

Prior Pregnancies/Births

Have you had prior pregnancies? YES NO If so, how many? _____ (regardless of outcome)

Did you find that your pregnancy, birthing or postpartum experiences were complicated, severe or traumatic?

YES NO If yes, please explain

Have you had a miscarriage, stillbirth or loss of an infant YES NO NA

Do you have other children in the home? YES NO If so, how many and what ages?

Partner, and Family & Friend Network

What's your current relationship status, do you have a partner? Circle what applies:

SINGLE MARRIED WIDOWED

COMMITTED-RELATIONSHIP-LIVING-TOGETHER

COMMITTED-RELATIONSHIP-NOT-LIVING-TOGETHER

Do you have a family and/or friend network (e.g., individuals you can count on for practical help and/or to talk through difficulties)? YES NO

Please Explain:

Do you feel you could ask your partner, family, or friend network for practical help and/or to talk through difficulties?

Please explain

Misc. Insights that Can Impact Your Mental Health and Well-Being

Are your partners (circle): MEN WOMEN BOTH OTHER NONE Prefer not to answer

Do you currently use tobacco or vape? YES NO Prefer not to answer

If yes, how much/how often? _____

Do you currently drink alcohol? YES NO Prefer not to answer

If yes, how much/how often? _____

Do you currently use cannabis or cannabis products like CBD? YES NO Prefer not to answer

If yes, how much/how often? _____

Do you have concerns about drug use and want help? YES NO

Do you have guns in your home? YES NO

Have you ever been a victim of unwanted sexual pressure, sexual abuse, or sexual violence?

YES NO Prefer not to answer

Do you currently feel physically safe at home? YES NO Prefer not to answer

Are you concerned about where you will live or get your next meal? YES NO Prefer not to answer

Do you have concerns about eating and/or pregnancy, weight gain or loss? YES NO

