



Comprehensive  
Reproductive Mental  
Healthcare

NAME:  
DATE:

DOB:

LIST OF CURRENT SYMPTOMS + REFERRING PROVIDER

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PAST PSYCHIATRIC HISTORY:

DIAGNOSIS(ES) / PROVIDERS (DATES) / ARE YOU CURRENTLY IN TREATMENT / ARE YOU IN THERAPY  
MAY I CONTACT YOUR PROVIDERS? PLEASE PROVIDE THEIR CONTACT INFORMATION IF POSSIBLE.

*FEEL FREE TO USE THE BACK IF NECESSARY*

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PAST MEDICATION TRIALS:

DATES, AGE, DOSES, ADVERSE REACTION(S)

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CURRENT MEDICATIONS INCLUDING SUPPLEMENTS

DOSES, PRESCRIBED BY, DATES OF USE

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HAVE YOU EVER BEEN PSYCHIATRICALY HOSPITALIZED:

WHY, DATES, HOSPITAL NAME

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MEDICAL PROBLEMS:

PROVIDER(S), DATE OF DIAGNOSIS, TREATMENT IN PAST/NOW

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DO YOU HAVE ANY DRUG OR FOOD ALLERGIES: (PLEASE USE THE BACK IF NEEDED)

TO WHAT MEDICATION(S) / REACTION(S)

NAME:

DOB:

**FAMILY HEALTH  
ASSOCIATES**

201 East 87th Street, #16J  
New York, NY 10128  
212-348-0175  
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cs@carllysnydermd.com



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DATE:

ARE YOU PREGNANT? ARE YOU HOPING/PLANNING TO CONCEIVE IN THE NEXT 6 MONTHS?

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NUMBER OF LIFETIME PREGNANCIES / NUMBER OF CHILDREN, DATE(S) OF BIRTH(S)?

MODE OF DELIVERY (C/S OR VAGINAL DELIVERY), WAS YOUR DELIVERY TRAUMATIC IN ANY WAY AND/OR AN EMERGENCY?  
(YOU ARE WELCOME TO EXPLAIN MORE ON THE BACK)

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DOES ANYONE IN YOUR FAMILY HAVE PSYCHIATRIC ILLNESS?

WHO/DIAGNOSIS/TREATED WITH? DID YOUR MOTHER/GRANDMOTHER SUFFER FROM ANY MOOD SYMPTOMS DURING OR AFTER PREGNANCY THAT YOU KNOW OF?

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DRUG(S)/ALCOHOL/TOBACCO USE?

AMOUNT DAILY/WEEKLY / CURRENT OF PAST USE  
WHEN DID YOU QUIT? HOW LONG DID YOU USE/ AGE AT HEAVIEST USE?

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ANYTHING ELSE YOU WANT ME TO KNOW PRIOR TO YOUR VISIT?

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HEIGHT: \_\_\_\_\_

WEIGHT: \_\_\_\_\_

IS THIS YOUR NORMAL WEIGHT? \_\_\_\_\_

IF NOT, WHAT IS YOUR AVERAGE WEIGHT? \_\_\_\_\_

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