



NIMHANS
DEPARTMENT OF PSYCHIATRY
PERINATAL PSYCHIATRY CLINIC

Registration form (Screening) – To be filled in at intake

DATE:

Name:

Age:

Unit:

P. No.:

Clinic registration No:

Diagnosis:

Duration of illness:

Reason For referral:

Current Menstrual History:

Parity: Nullipara /Primipara /Multipara

Any H/o abortion/MTP/Still birth:

Present / Absent

If present was it associated with psychotropic use

Yes / No

Description Current Episode –

Duration

Onset – to reproductive event

Pregnancy

I Trimester

II Trimester

III Trimester

Postpartum

Presenting Complaints:

LIFE CHART

Draw Life Chart below

Family History:

Yes / No

Relationship to Patient

Bipolar Disorder

Any Postpartum illness

Depressive disorder

Suicide

Psychosis

Any Significant Personality problems: Present/Absent

If present details:

Marital History:

Duration of Marriage:

No. of Children:

Marital relationship – as perceived by the patient: Good / Problems present

H/o Domestic Violence in the past 1 year: Yes / No.

CONTRACEPTION:

Any family planning advise given to the patient by the treating team Yes / No

Any use of contraception Yes / No

If yes What Contraception method?

Barrier method

OCP

IUD

Rhythm method

