The Johns Hopkins   
Reproductive Mental Health Center 

Menstrual Cycle-Related Mood Symptoms Evaluation Questionnaire

Please answer as completely as possible. When you are finished, please email this form to the clinical administrator at [RMHCADMIN@jh.edu](mailto:RMHCADMIN@jh.edu) or fax 410-502-3755.

Once you have returned this form, we will contact you to provide you with some possible dates for your evaluation. Please check your email and respond in less than one week or your appointment slot may be given to the next patient on our waitlist.

1. Who referred you to our program?
   1. Self-Referred
   2. Provider -- NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   3. Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Please tell us in one to two sentences why you are seeking this evaluation.
3. What services are you interested in receiving? (**Please place in order of priority -- 1st priority, 2nd priority and 3rd priority**)

A. Therapy/counseling

B. Ongoing Medication management

C. Evaluation appointment with recommendations about medication management sent to my current provider.

1. Are you seeking a one-time evaluation or ongoing medication management care?
   1. One-time evaluation
   2. Ongoing medication management
   3. All the above if available

(Please note that if you are looking to establish ongoing care at our clinic, this will be discussed during your initial evaluation. Please note that we cannot guarantee ongoing care as spots are limited. You should not assume that any new medications will be prescribed at your evaluation appointment or that you will be able to establish care at our clinic during your evaluation appointment.)

1. What is your preferred language?
2. Do you require an interpreter? **YES** **NO**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **PATIENT INFORMATION FORM** | | | | | | |
| **DEMOGRAPHICS** | | | | | | |
| **Existing Hopkins Patient:** | | | **New Patient YES/NO** | | | |
| Name: | | | | | | |
| Date of birth: | | SSN: | | | | Race: |
| Religion: | | Country of Birth: | | | | Marital Status: |
| Address: | | | | | | |
| City: | | State: | | | | ZIP Code: |
| Phone: | | Cell: | | | | |
| Male \_\_\_\_ Female\_\_\_\_\_\_ non-binary \_\_\_\_\_\_ Mother’s Maiden Name: | | | | | | |
| Email: (If we may contact you by email) | | | | | | |
| **EMERGENCY:** | | | | | | |
| Name: | | | | Relationship: | | |
| Address: | | | | | | |
| Phone: | | | | Email: | | |
| **MEDICAL INFORMATION:** | | | | | | |
|  | | | | | | |
| Clinical Diagnosis: | | | | | | |
| Treating Psychiatrist (Name, address): | | | | | | |
| Treating Therapist/Counselor (Name, address): | | | | | | |
| Primary Care Physician (Name, address): | | | | | | |
| Psychiatrically Hospitalized: Y/N - Yes | If yes, When: | | | | | |
| Current Medications (names and dosage): | | | | | | |
|  | | | | | | |
| Allergies: | | | | | | |
| \*Is this appointment accident related? Y/N | | | | | | |
| \*Preferred Language: | | | | Need Translator: Y/N | | |
| **INSURANCE** | | | | | | |
|  | | | | | | |
| **Primary Insurance Name:** | | | | | **Subscriber:** | |
| In Network? Y N | | Fee Due at Time of Service: | | | | |
| **Member ID:** | | | | | | |
|  | | | | | | |
| **Secondary Insurance Name:** | | | | | **Subscriber:** | |
| In Network: Y N | |  | | | | |
| **Member ID:** | | | | | | |
| Additional Information: | | | | | | |
|  | | | | | | |

**These questions pertain to your regular monthly cycles and premenstrual symptoms. Please respond to all questions that apply to you.**

1. How old were you when you had your first menstrual period? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. During your first year of menstruation, did you have regular monthly periods? (By regular periods, we mean that your first day of menstruation

was predictable within 10 days.) (circle or check) **YES** **NO**

At what age did they become regular? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\**If you have never had regular monthly periods, please check here* \_\_\_\_

1. How long is your average menstrual cycle? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\**This is measured from the first day of bleeding to the next first day of bleeding. If your cycle has always been too irregular to give a reasonable estimate, please indicate that.*

If you have never experienced any premenstrual symptoms, this is not the form for you! Please check [our website](https://www.hopkinsmedicine.org/psychiatry/specialty_areas/moods/patient_information/clinic_women.html) to choose the correct form for your type of evaluation.

1. At what age did you first experience premenstrual symptoms? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Was there a time in your life when these symptoms were worse than others? **YES** **NO**

If so between what ages? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were there any precipitating or exacerbating factors? **YES** **NO**

If so, please describe. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you get PMS symptoms consistently every month? **YES**  **NO**

If no, please indicate how frequently you get them:

( ) About 75% of the time (approximately 9 months per year)

( ) About 50% of the time (approximately 6 months per year)

( ) About 25% of the time (approximately 3 months per year)

( ) Only occasionally or rarely (1-2 months per year)

1. How long do your PMS symptoms last, on average?

( ) 1 day

( ) 2-3 days

( ) 4-5 days

( ) 6-7 days

( ) >8 days

**The following chart describes some symptoms that may be associated with premenstrual syndrome. Premenstrual syndrome (PMS) is a group of symptoms related to the menstrual cycle. PMS symptoms occur in the week or two weeks before your period (menstruation or monthly bleeding). The symptoms usually go away after your period starts. PMS may interfere with your normal activities at home, school, or work. Please review the chart and check the box that indicates the extent to which the symptoms bother you during the premenstrual time period.**

Have you experienced the following premenstrual symptoms, which ***start at least several days before*** your period and ***stop*** within a few days of bleeding?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Symptom | Not at all | Mild | Moderate | Severe |
| 1. Anger/irritability |  |  |  |  |
| 2. Anxiety/tension |  |  |  |  |
| 3. Tearful/Increased sensitivity to rejection |  |  |  |  |
| 4. Depressed Mood/Hopelessness |  |  |  |  |
| 5. Decreased interest in work activities |  |  |  |  |
| 6. Decreased interest in home activities |  |  |  |  |
| 7. Decreased interest in social activities |  |  |  |  |
| 8. Difficulty concentrating |  |  |  |  |
| 9. Fatigue/lack of energy |  |  |  |  |
| Symptom | Not at all | Mild | Moderate | Severe |
| 10. Overeating/food cravings |  |  |  |  |
| 11. Insomnia |  |  |  |  |
| 12. Hypersomnia (needing more sleep) |  |  |  |  |
| 13. Feeling overwhelmed or out of control |  |  |  |  |
| 14. Physical symptoms: breast tenderness, headaches, joint/muscle pain, bloating, weight gain |  |  |  |  |
| 15. Recurrent, unwanted, intrusive ideas, images, or impulses that seem silly or horrible |  |  |  |  |
| 16. Feelings of elation; having periods of increased activity; or needing less sleep. |  |  |  |  |
| 17. Feeling the need to check things over and over, or repeat actions over and over, to prevent bad things from happening. |  |  |  |  |
| 18. Having panic attacks. (Panic attacks are sudden unexpected episodes of anxiety often associated with physical symptoms such as rapid heartbeat, feeling faint, lightheaded, trembling, chest tightness, or shortness of breath; lasting approximately 10 minutes) |  |  |  |  |

**Have your symptoms, as listed above, interfered with:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Not at all** | **Mild** | **Moderate** | **Severe** |
| A. Your work efficiency |  |  |  |  |
| B. Your relationships with coworkers |  |  |  |  |
| C. Your relationships with your family |  |  |  |  |
| D. Your social life activities |  |  |  |  |
| E. Your home responsibilities |  |  |  |  |

## 

Thank you! The information above is all that we will need to schedule your appointment. Below is a checklist to help you prepare for your appointment – please ensure that items on this list are received **at least two weeks before your appointment**.

**Please obtain:**

REQUIRED:

□ Typed summary of care letter from your psychiatric provider. The summary of care should include your primary psychiatric diagnoses and medication trials to date (preferably with dates, efficacy, side effects and reasons medication discontinued). Your provider may use this table [(link to medication table form – Word file here](https://www.hopkinsmedicine.org/psychiatry/specialty_areas/moods/patient_information/docs/women/WRMH_Medication_Table_Jul2021.docx)) to summarize medication trials to date. The link to this form can also be found on our website.

□ Signed Release of information ([link to pdf form](https://www.hopkinsmedicine.org/the_johns_hopkins_hospital/_docs/a_2_1_a_providers_authorization.pdf)) to receive your information and send our recommendations to your current psychiatric providers. The link to this form also be found on our website.

PREFERRED (if available, but not required at first appt):

□ Summary of care from any treating therapist/counselor.

\*\*\*\* Failure to return the required items on the above checklist at least two weeks prior to your evaluation appointment may result in our needing to cancel or reschedule. Please sign below indicating that you have read this information and are in agreement with these terms.

SIGNATURE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Cancellation Policy/No Show Policy**

We’re glad you have chosen us to provide your medical care. If you miss your appointments, you compromise your care. We want to remind you of our office policies regarding missed appointments.

A missed appointment is when you fail to show up for an appointment without a phone call or cancel without prior notification.

We strive to be on time for your scheduled appointment and ask that you give us the courtesy of a call when you are unable to keep your appointment. We have outlined our missed appointment policies below.

**New Patient Consultations**

We require 48 business hour notice for all new patient appointment cancellations otherwise a $250 no show fee that is not covered by insurance will be charged.

**Follow-up Office Visits**

We require 24 business hour notice for all routine office visits otherwise a $50 no show fee will be charged.

* 1st missed follow up appointment: We’ll call and offer to reschedule your appointment. You may be charged a missed appointment fee of $50.
* 2nd missed follow up appointment: You will receive written notification of your missed appointment and will be charged a fee of $50.
* 3rd missed follow up appointment: You will be charged an additional missed appointment fee of $50. This may also result in a discharge from the practice.

**Late Policy:**

We allow a 15-minute grace period from your appointment start time. However, if you are late your appointment will be cut short to maintain clinic schedule. If you arrive after 15-minutes from the start of your appointment, you may not be seen and will be rescheduled.

**Term of Care:**

Our psychiatric providers have completed additional training to gain expertise in the management of psychiatric disorders across pregnancy and in the postpartum. To help provide our expertise to more patients, we may provide time-limited clinical care while you are pregnant and up to one year postpartum. At one year postpartum, we will help provide referrals to help you transition your care to a general psychiatrist, therapist, or primary care doctor (as deemed appropriate). We are also happy to act as consultants to your treating providers (in which case they will be prescribing your medications) during pregnancy and up to one year postpartum.

By signing below you are indicating that you have read and are in agreement with our clinic policies and terms.

Signature of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_