Jennifer Teitelbaum Palmer M.D.
P.O. Box 50340, Baltimore, MD 21211

PERSONAL INFORMATION - Please fill out this form as completely as you can. Please print your answers.

Today's Date		Ethnic Identity	
First Name		Gender Identity	
Last Name		Marital Status	
Birthdate		Occupation	
Social Security Number		Religion (if an important part of your identity)	

Contact Information - Please give your home address. Please circle the appropriate letter letting me know if I can leave a full message (M), call-back number only (C), or no message (N).

Address		Home Phone	M C N
City		Cell Phone	M C N
State		Work Phone	M C N
Zip Code		Email	M C N

Emergency Contact - Please tell me the name of someone to contact in an emergency.

Name			
Best Phone			
Email			
Relationship			

Insurance Information - Although I do not participate with any insurance plans, it is sometimes helpful for me to have your insurance information in case you need hospitalization.

Plan Name		Policy Number	
Subscriber		Group Number	

Pharmacy - Please provide contact information for the primary pharmacy you use for your prescriptions.

Pharmacy Name		Phone	
Pharmacy Plan Number(s) (from insurance card)		Rx BIN (on insurance card)	

Referral Source - Please tell me who suggested that you see me.

Name		Relationship	
Phone		Fax	

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DOCTORS AND THERAPISTS- Please list all doctors and therapists you see regularly. Please also list any past psychiatrists and therapists and when you last saw them. Continue on back if needed.

Name		Type of Doctor	
Phone		Past of Current?	
Fax		Date last seen	

Name		Type of Doctor	
Phone		Past of Current?	
Fax		Date last seen	

Name		Type of Doctor	
Phone		Past of Current?	
Fax		Date last seen	

Name		Type of Doctor	
Phone		Past of Current?	
Fax		Date last seen	

Name		Type of Doctor	
Phone		Past of Current?	
Fax		Date last seen	

MEDICAL HISTORY

Medical Problems - Please list all major medical problems, injuries and treatments. Continues on next page. Continue on back if needed.

Medical Problem	When Diagnosed	Treatment(s)	Treatment Dates

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Surgeries - Please list all surgeries you have had, when and for what conditions. Continue on back if needed.

Operation	When Performed	Reason for Procedure

Current Medications and Supplements - Please list all medications and supplements (prescribed and over-the-counter) you take regularly. Continue on back if needed.

Medication Name	Dose	Frequency	Reason Prescribed

Allergies and Adverse Reactions - Please list any medications or foods to which you have had a bad reaction, including problems with anesthesia. Continue on back if needed.

Medication or Food	Reaction

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Substance History - For any substances you have used, please indicate date of last use, the maximum amount and frequency used, and whether you ever used it intravenously if applicable. Continue on back if needed.

Substance	Last Used	Max Amount	Max Frequency	Ever Used I.V.?
Alcohol				
Cocaine				
Marijuana				
Hallucinogens				
Inhalants				
Heroin or opioid pain medication				
Amphetamines, bath salts, prescribed stimulants				
Sedatives				
Tobacco products				

Recent Symptoms and Tests - Please check any symptoms and/or tests you have had in the past year. Please indicate which body part was tested where applicable (Xray of: chest, e.g.). Continue on back if needed.

□Fatigue	□Swollen legs or □feet	□Anemia	□Seizures
□Fever	□Calf pain	Easy □bruising □bleeding	□X-ray of:
Unintentional weight □loss □gain	□Difficulty swallowing	□Rash	□CT scan of:
□Night sweats or hot flashes	□Heartburn	□Changes in moles	□MRI of:
□Enlarged lymph nodes	□Chest pain	New breast □lump □discharge □skin change	□Ultrasound of:
□Intolerance to □cold □heat	□Shortness of breath	New testicular □lump □swelling	□EKG
Increased □thirst □appetite □urination	□Nausea □Vomiting □Diarrhea □Constipation	Pain in □joints □muscles	□Stress test
□Loss of appetite	□Bloody □black or □clay-colored stool	□Limb or □face □numbness or □weakness	□EEG
Hair □loss or □changes	Yellow □skin □eyes	□Headaches	□Others not listed:
□Hearing or □vision problems	□Trouble urinating	□Memory problems	
□Nosebleeds	□Bloody □pink □coca-cola colored urine	□Coordination problems	
□Mouth sores or □dental problems	□Abnormal vaginal bleeding □missed periods □genital discharge	□Dizziness or □fainting	

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PAST PSYCHIATRIC HISTORY

Psychiatric Hospitalizations - Please list any psychiatric hospitalizations you have had. Continue on back if needed.

Hospital Name	Dates in Hospital	Reason Admitted

Past Psychiatric Medications - Please list names of any psychiatric medications (such as antidepressants, antipsychotics, mood stabilizers, stimulants, sedatives) that you remember taking in the past. Continue on back if needed.

Medication Name	When Prescribed	Frequency (if known)	Max Dose (if known)	How Long Taken at Max Dose (if known)

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FAMILY PSYCHIATRIC HISTORY

Family Psychiatric Illness History - Please list any blood relatives diagnosed with a mental illness. Continue on back if needed.

Relation to You	Gender	Diagnosis (check all that apply)	Treatment (check all that apply)
		□Depression □Anxiety □Bipolar Disorder □Schizophrenia □Other:	□Therapy/counseling □Medication □Hospitalization
		□Depression □Anxiety □Bipolar Disorder □Schizophrenia □Other:	□Therapy/counseling □Medication □Hospitalization
		□Depression □Anxiety □Bipolar Disorder □Schizophrenia □Other:	□Therapy/counseling □Medication □Hospitalization
		□Depression □Anxiety □Bipolar Disorder □Schizophrenia □Other:	□Therapy/counseling □Medication □Hospitalization
		□Depression □Anxiety □Bipolar Disorder □Schizophrenia □Other:	□Therapy/counseling □Medication □Hospitalization
		□Depression □Anxiety □Bipolar Disorder □Schizophrenia □Other:	□Therapy/counseling □Medication □Hospitalization

Family Suicide History - Please list any blood relatives who have died by suicide. Continue on back if needed.

Relation to You	Gender	Age at Suicide

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Current Psychiatric Symptoms - Please check any symptoms you are experiencing now. Continue on back if needed.

□Sad or □don't care	Difficulty at □school or □work	□Not needing much sleep	□Can't throw things away
□Irritability	□Can't make decisions	Uncharacteristic □impulsive or □dangerous behavior	□Generalized anxiety feelings
□Trouble concentrating	□Don't enjoy things	□Racing thoughts, □feeling talkative or □talking loud	□Panic attacks
Appetite □increase or □decrease	□Not good at things	Lots of □new plans or □insights	□Binge eating
Trouble □falling asleep or □staying asleep	□Guilt over bad deeds or □deserve punishment	□Suspicious of others trying to harm you	□Afraid to get fat
□Poor energy	□Worrying about health or even □rotting from the inside from disease	Thoughts being □inserted □removed □blocked □broadcast by outside force	□Starving self to control weight
□Poor motivation	□Feeling worthless or □hopeless	□Getting messages from the radio or TV	□Vomiting, □laxative or □diuretic use to control weight
□Trouble getting started	□Life is not worth living	□Arms and legs being moved against your will by an outside force	□Overexercising to control weight
□Not getting out	□Thoughts of suicide	□Hearing or □seeing things	□Others not listed:
□Interpersonal difficulty, even □physical altercations	□Cutting or □hurting self	Needing to □count or □check things	
□Interacting less	□Too much energy	□Afraid of or □avoid things	

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WOMEN'S HISTORY QUESTIONS

Family Postpartum History - Please list any female blood relatives who suffered from an episode of mental illness that began soon (roughly within the first year) after giving birth. Continue on back if needed.

Female Relative	Post-Partum Diagnosis (please check all that apply)	
	□Depression or □Anxiety Disorder □Bipolar Disorder	□Schizophrenia or □Psychosis □Other:
	□Depression or □Anxiety Disorder □Bipolar Disorder	□Schizophrenia or □Psychosis □Other:
	□Depression or □Anxiety Disorder □Bipolar Disorder	□Schizophrenia or □Psychosis □Other:
	□Depression or □Anxiety Disorder □Bipolar Disorder	□Schizophrenia or □Psychosis □Other:
	□Depression or □Anxiety Disorder □Bipolar Disorder	□Schizophrenia or □Psychosis □Other:

Reproductive Events - Please indicate the number of events and in what year(s) they occurred.

Event	Number	When Occurred
Live births		
Miscarriages		
Elective abortions		
Stillbirths or 3rd trimester losses		

Menstrual History

Age at your first menstrual period?	
Are your cycles regular?	
Date of your last menstrual period?	

Premenstrual Symptoms - Have you experienced symptoms that start before your period and stop with bleeding onset? Please check severity level of each.

Symptom	None	Mild	Moderate	Severe
Depressed mood/hopelessness/self-deprecating thoughts				
Anxiety/tension/feeling "keyed up" or "on edge"				
Easily sad/tearful/increased sensitivity to rejection				
Anger/irritability				
Decreased interest in usual activities				
Difficulty concentrating				

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Symptom	None	Mild	Moderate	Severe
Fatigue/lack of energy				
Overeating/specific food cravings				
Insomnia OR sleeping more than usual (circle one)				
Feeling overwhelmed/out of control				
Breast tenderness, headache, joint/muscle pain, bloating				

How badly have these symptoms interfered with your:	None	Mild	Moderate	Severe
Work and/or home responsibilities?				
Social activities?				
Relationships with family, friends and coworkers?				
If yes to any of the above symptoms, do they occur with every or most cycle(s)?				

Reproductive Treatments and Mood Symptoms - Please indicate whether hormone treatments have affected your mood in any way, and whether you have ever experienced a postpartum mood episode. Continue on back if needed.

Have you ever used a hormone birth control method (pills, Nuva Ring, Patch, IUD) or other hormone treatment (such as for polycystic ovarian syndrome or missed menses) or hormone replacement therapy?	If yes, which treatments?
Did you experience any mood changes (better or worse) with these treatments?	If yes, please describe:
Have you experienced any mood symptoms that started within 4 weeks of delivery or pregnancy termination?	If yes, please describe: