

Jennifer Teitelbaum Palmer M.D.

3355 Keswick Road ♦ Suite 100
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.

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

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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)
		<input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Bipolar Disorder <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Other:	<input type="checkbox"/> Therapy/counseling <input type="checkbox"/> Medication <input type="checkbox"/> Hospitalization
		<input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Bipolar Disorder <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Other:	<input type="checkbox"/> Therapy/counseling <input type="checkbox"/> Medication <input type="checkbox"/> Hospitalization
		<input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Bipolar Disorder <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Other:	<input type="checkbox"/> Therapy/counseling <input type="checkbox"/> Medication <input type="checkbox"/> Hospitalization
		<input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Bipolar Disorder <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Other:	<input type="checkbox"/> Therapy/counseling <input type="checkbox"/> Medication <input type="checkbox"/> Hospitalization
		<input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Bipolar Disorder <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Other:	<input type="checkbox"/> Therapy/counseling <input type="checkbox"/> Medication <input type="checkbox"/> Hospitalization
		<input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Bipolar Disorder <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Other:	<input type="checkbox"/> Therapy/counseling <input type="checkbox"/> Medication <input type="checkbox"/> 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.

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