Miriam Tetelbom MD LLC

316 Broad Street suite # 3 Red Bank NJ 07701

280 Madison Avenue suite # 506 New York NY 10016

Name:_____ Date:_____

Date of Birth: _____ Age: _____

Home address: _____

City: _____ State: _____ Postal Code: _____

Telephone: home: _____ work: _____

Mobile: _____ Email: _____

Profession: _____

Circulate your answers:

1) Male / Female

2) Married / Single / Lives with partner / Divorced Widowed

3) Education: Primary / High School / Technical Course / Incomplete-Complete College / Master's / Doctorate

4) Emergency contact: Name: _____

Address: _____

Telephone: home: _____ cellular: _____

Relationship:_____

By providing a contact person's information in emergency situations, I am authorizing Dr. Miriam Tetelbom to call and / or write to that person if necessary in a medical emergency and opening information such as diagnosis-treatment-recommendations for this person who were during treatment for Dr. Miriam Tetelbom.Please clarify if you prefer that any specific information is not open to that person. My initials _____ Date:_____

Pharmacy Name:_____

Address (including postal code):_____

Telephone:_____

Reason for consultation:_____

Has a psychological / psychiatric problem been diagnosed?_____

What? _____ When? _____
Which professional? _____

Please list the medications for emotional problems you are currently taking and those you have used in the past:

Medication and dosage	Was it helpful?	Duration of use	Undesirable effects

Have you looked for other ways of helping to try to solve this problem that you are looking for help such as: (circle your answer) home remedies, remedies you bought at the pharmacy without a prescription, psychotherapy, natural treatments, vitamins, acupuncture, alternative treatments, spiritual treatments, others. Provide details:

Vitamin/supplement	Duration of use	Was it helpful?	Undesirable effects

Other treatments	duration	result	Undesirable effects

Are you doing psychotherapy?: _____ Name of professional: _____ credentials: _____ in person or remotely?_____

Have you ever been to a hospital emergency room for psychological / psychiatric problems? _____ What problem did you need help with at that time? _____ Dates: _____ Place: _____

Have you ever been admitted to a hospital for psychiatric treatment? What is the date _____ and the reason?
_____

Alcohol and Substances: Circulate the substances you used in the last month: Cigarette / Nicotine/Alcohol / Marijuana / synthetic marijuana / Cocaine / Crack / Heroin / other opioids / LSD/ Hallucinogens/ juul/other.clarify amount and frequency:

Indicate if you have already had any treatment due to the problematic use of any substance: circle and describe the details below: Detox / rehab / groups / counseling / AA / NA:
_____
_____

Name of your doctor (general practitioner, family doctor):_____Telephone: _____

Are you using any medication prescribed or not by your primary doctor?

problem	medication / supplement	Dosage

Date of your last annual physical exam:_____

Did you have allergies to medicines / food / allergens from the environment and what reactions you have:

Family History: were psychiatric disorders diagnosed or not by a doctor in your blood relatives (father, mother, brothers, sisters, uncles, grandparents, cousins, children) such as anxiety / depression / bipolar / schizophrenia / suicide attempt / problematic use of alcohol or substances

relatives	Condition

Who is filling out this questionnaire: _____

Signature: _____

Date: _____