Samuel H. Blumberg, Ph.D.

2300 Pennsylvania Avenue, Suite 4D • Wilmington, DE 19806 • 302 652 7733

Date: _____

Patient's Name: _____ Date of Birth: _____
Address: _____
_____
Phone Number: _____

Name of Person Completing this form (if different from above): _____

Marital/Relationship Status: __ Married __ Single __ Divorced __ Living with Partner

Employment/Education: __ Employed __ Full-time student __ Part-Time Student

Emergency Contact: _____ Phone Number: _____

Children (Names, ages): _____

For Child and Adolescent Patients:

Mother's Name: _____ Father's Name: _____
Address: _____ Address: _____
_____ _____
Phone #: _____ Phone #: _____

Insurance

Insurance Company: _____
Identification Number: _____ Group/Account Number: _____
Name of Insurance Plan: _____
Name of Subscriber: _____ Subscriber Date of Birth: _____
Subscriber relationship to patient: __ Self __ Spouse __ Parent __ Other: _____
Subscriber Address (if different from above): _____
_____
Subscriber's Employer: _____
Other Health Insurance: _____

Primary Concerns (Check all that Apply):

__ Depression
__ Irritable
__ Sleep problems
__ Difficulty concentrating
__ Appetite change (Increase or decrease)
__ Weight gain or loss
__ Decreased energy
__ Periods of increased energy
__ Impulsive
__ Conduct problems
__ High activity level
__ Anxiety
__ Panic Attacks
__ Problems with eating
__ Problems with thinking clearly
__ Difficulty with relationship
__ Sexual Problems

__ Other (Describe): _____

How long have you had these problems? _____
Check if problems are related to: __ Auto Accident __ Other Accident __ Employment incident

Recent Stresses (Check all that apply and describe):

__ Family Stress: _____
__ Deaths: _____
__ Illness: _____
__ Injury: _____
__ Job stress: _____
__ Accident: _____
__ Crime victim: _____
__ Other: _____

__ History of Trauma: _____

Medical History

Primary Care Physician: _____ Telephone # _____
Date of last physical examination: _____

Illnesses:

__ Diabetes
__ Hypertension
__ Cancer
__ Epilepsy/seizures
__ Asthma
__ Heart Disease
__ Stroke
__ Lung disease
__ Headaches/migraines
__ Arthritis
__ Other: _____

Allergies: __ Yes __ No, If Yes, describe: _____

Surgeries:

Date Type of Surgery

_____
_____
_____

Serious Accidents and Head Injuries

Date Type of Injury

_____
_____
_____

Medications

Name of Medicine Dose Prescribing Physician Side Effects

_____
_____
_____
_____
_____

Alcohol Use

Amount of Use: _____ Frequency of use: _____
Previous treatment for alcohol problems: __ Yes __ No, If Yes, when: _____

Drug Use (including abuse of prescription and over the counter drugs)

Drug Use: __ Yes __ No, If Yes, Types of drugs: _____
Amount of use: _____ Frequency of use: _____
Previous treatment for drug problems: __ Yes __ No, If Yes, when: _____

Tobacco Use

Amount smoke per day: _____ Age started smoking: _____

Previous psychiatric treatment:

Date Name of Provider

_____
_____
_____

Job History

Current Job: _____ Date Started: _____ History of Losing Jobs: __ Yes __ No

Hobbies/Interests: _____

Legal History

__ History of Arrests, Reasons: _____

For Child and Adolescent Patients

Developmental History
__ Difficulties with pregnancy, describe: _____
__ Difficulties with childbirth, describe: _____
__ Drug/Alcohol use during pregnancy, describe: _____

Age started walking: _____
Age started talking: _____
Age toilet trained: _____

Immunizations
Are all immunizations up to date? __ Yes __ No
If No, Please explain why: _____

Academic History
Current School: _____ Grade: _____
__ Academic Problems, describe: _____
__ Special Education
__ Discipline Problems
__ School Refusal

Grades on most recent report card
_____ English/Language Arts
_____ Mathematics
_____ History/Social Studies
_____ Science

For Office Use Only

Reviewed by: _____ Date: _____