**WELCOME TO OUR OFFICE** Today’s **Date: \_\_\_\_\_\_\_\_\_\_**

**Greater Orlando Psychiatric Associates, P.A.**

1417 N. Semoran Blvd, Suite 203

Orlando, FL 32807

Phone: (407) 206-1106 Fax: (407) 206-1112

**PATIENT DEMOGRAPHIC INFORMATION:**

| Name: | | Social Security Number: | | | Date of Birth: | | Gender: |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Street Address: | | Apt Number: | City: | | | State: | Zip Code: |
| Primary Phone # (☐ Cell / ☐ Home): | Secondary Phone #(☐ Cell / ☐ Home): | | | E-mail Address: | | | |
| Ethnicity: ☐ Hispanic ☐ Non-Hispanic | Race: ☐ American Indian ☐ Asian ☐ Black ☐ White ☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_ ☐ Decline to specify | | | | | | |

**GUARANTOR INFORMATION:** Required if patient is under 18 years old or if a court has appointed guardianship due to incapacity/disability.

| Parent/Legal Guardian Name: | Social Security Number: | | | Birth Date: | Day Time Phone: | |
| --- | --- | --- | --- | --- | --- | --- |
| Street Address: (If different from patient) | | Apt Number: | City: | | State: | Zip Code: |

**PREFERRED PHARMACY:**

| Pharmacy Name: | Pharmacy Phone: | Location: |
| --- | --- | --- |

**EMERGENCY CONTACT:**

| Name: | Phone: | Relationship: |
| --- | --- | --- |

**INSURANCE INFORMATION: Attach copy of front and back of insurance card (s)**

| **Do you have Medical Insurance?** ☐ Yes ☐ No | Type of Insurance(s):  ☐ Employer/Group Plan ☐ Medicare/MA ☐ Tricare/ChampVA ☐ ACA (Marketplace) ☐ Other: | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Primary Insurance Company:** | | | | Policy/Member ID#: | | Group# | | | Is this policy through an employer? ☐ Yes ☐ No  If yes, Employer Name: |
| Relationship to Policyholder:  ☐ Self ☐ Spouse ☐ Child ☐ Other | | | Name of Policy Holder (if not patient): | | | Date of Birth: | | Address: (if different than patient) | |
| **Secondary/Supplemental Insurance:** | | | | Policy/Member ID# | | Group # | | | Is this policy through an employer? ☐ Yes ☐ No  If yes, Employer Name: |
| Relationship to Policyholder:  ☐ Self ☐ Spouse ☐ Child ☐ Other | | Name of Policy Holder (if not Self): | | | Date of Birth: | | Address (if different from patient): | | |

I declare the above information is true and authorize Greater Orlando Psychiatric Associates, P.A. to release any information necessary to my insurance carrier for authorization or payment of services. I understand that I am responsible for all charges regardless of insurance coverage.

Patient or Guarantor Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_**

| Who referred you to us? |
| --- |
| In your own words, briefly describe your reason for seeking treatment and problems as you see them: |
| Current Stressors: |

**Most recent Symptoms: Are you currently having any of the following problems? (check all that apply)**

| ☐ Depressed mood | ☐ Crying/tearful episodes | ☐ Isolating/social withdraw |
| --- | --- | --- |
| ☐ Isolating/social withdraw | ☐ Loss of interest in activities | ☐ Thoughts of death |
| ☐ Feeling worthless | ☐ Frequent feelings of guilt | ☐ Hopeless/helpless |
| ☐ Irritability | ☐ Rapid mood changes | ☐ Anger outbursts |
| ☐ Decreased energy | ☐ Increased energy | ☐ Unexplained body aches/pain |
| ☐ Anxiety | ☐ Panic attacks | ☐ Difficulty leaving your home |
| ☐ Feeling on edge | ☐ Racing thoughts | ☐ Increased appetite |
| ☐ Trauma/Abuse exposure | ☐ Recent upsetting loss: | ☐ Decreased need for sleep |
| ☐ Intrusive memories | ☐ Avoidance | ☐ Nightmares |
| ☐ Severe fear/phobia | ☐ Suspiciousness | ☐ Hallucinations |
| ☐ Repetitive behaviors or mental acts (i.e., counting, checking doors) | | ☐ Self-mutilation/cutting |
| ☐ Difficulty concentrating | ☐ Memory loss | ☐ Learning problems |
| ☐ Forgetfulness | ☐ Episodes of confusion | ☐ Disassociation |
| ☐ Impulsivity | ☐ Hyperactivity | ☐ Difficulty completing tasks |
| ☐ Sleep Disturbances; | ☐ Difficulty falling asleep | ☐ Difficulty staying asleep |
| ☐ Appetite changes; | ☐ Increased sleeping |  |
| ☐ Decreased appetite | ☐ Unintended weight loss or gain, if so, how much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |

# PAST PSYCHIATRIC HISTORY:

**Have previously received mental health treatment?** ☐No ☐Yes If yes, please provide as much detail as you recall

| **Treatment Date(s):** | **Name of Provider:** | **Reason for seeking treatment:** | **Treatment Type:** (Medications, Psychotherapy, Marriage counseling, ECT) |
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**Have you ever been hospitalized for psychiatric reasons?** ☐No ☐Yes If yes, when/where?

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| --- |

# MEDICAL HISTORY:

Current / Past medical illnesses:

| ☐ Anemia | ☐ Emphysema/COPD | ☐ Kidney Disease | ☐ |
| --- | --- | --- | --- |
| ☐ Asthma | ☐ Fibromyalgia | ☐ Liver Disease | ☐ |
| ☐ Cancer, type:\_\_\_\_\_\_\_\_\_\_\_\_\_ | ☐ Heart Disease | ☐ Seizures | ☐ |
| ☐ Chronic Pain | ☐ High Cholesterol | ☐ Stroke | ☐ |
| ☐ Diabetes / Pre-diabetes | ☐ Hypertension | ☐ Thyroid Disease | ☐ |
| Please include any other medical conditions that you’ve been diagnosed with: | | | |

| CURRENT MEDICATIONS: Please list all medications you are presently taking or attach a separate list. | | | | |
| --- | --- | --- | --- | --- |
| Medication Name | Dosage/Frequency |  | Medication Name | Dosage/Frequency |
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**ALLERGIES**

Have you had an allergic reaction to medication(s)? ☐No ☐Yes If yes, please list names and the reactions they cause:

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| --- |
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## SOCIAL HISTORY

| Marital Status: |
| --- |
| Number of Children: |
| Occupation: |
| Tobacco use: ☐ No ☐ Yes \_\_\_\_\_\_\_\_\_\_\_\_ per day |
| Alcohol Use ☐ No ☐ Yes \_\_\_\_\_\_\_\_\_\_\_\_ drinks per week |

| **CONSTITUTIONAL**:  Yes No   * ☐Weight Loss * ☐ Fatigue * ☐ Fever   **EYES:**  Yes No   * ☐ Glasses/Contacts * ☐ Eye Pain * ☐ Double Vision * ☐ Cataracts   **EAR, NOSE, THROAT:**  Yes No   * ☐ Difficulty Hearing * ☐ Ringing in Ears * ☐ Vertigo * ☐ Sinus Trouble * ☐ Nasal Stuffiness * ☐ Frequent Sore Throat   **CARDIOVASCULAR:**  Yes No   * ☐ Murmur * ☐ Chest Pain * ☐ Palpitations * ☐ Dizziness * ☐ Fainting Spells * ☐ Shortness of Breath * ☐ Difficulty lying Flat * ☐ Swelling Ankles   **ALLERGIC/IMMUNOLOGIC**:  Yes No   * ☐ Hives/Eczema * ☐ Hay Fever * \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **ENDOCRINE:**  Yes No   * ☐ Diabetes * ☐ Excessive sweating * ☐ Heat/cold intolerance * ☐ Increased thirst/appetite * ☐ Thyroid dysfunction   **RESPIRATORY:**  Yes No   * ☐ Asthma * ☐ Shortness of breath * ☐ Wheezing * ☐ Emphysema   **GASTROINTESTINAL**:  Yes No   * ☐ Heartburn/Reflux * ☐ Nausea/Vomiting * ☐ Constipation * ☐ Diarrhea * ☐ Abdominal Pain * ☐ Blood in stool   **GENITOURINARY:**  Yes No   * ☐ Urinary/bladder infections * ☐ Nighttime frequency * ☐ Urinary retention * ☐ Blood in Urine * ☐ Erectile Dysfunction * ☐ Abnormal Discharge * ☐ Bladder Leakage | **HEMATOLOGY/LYMPH:**  Yes No   * ☐ Easy Bruising * ☐ Gums Bleed Easily * ☐ Enlarged Glands   **MUSCULOSKELETAL:**  Yes No   * ☐ Joint Pain/Swelling * ☐ Stiffness * ☐ Muscle Tension * ☐ Back Pain * \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   **SKIN:**  Yes No   * ☐ Rash/Sores * ☐ Lesions * ☐ Itching/Burning   **NEUROLOGICAL:**  Yes No   * ☐ Loss of Strength * ☐ Numbness * ☐ Headaches * ☐ Tremors * ☐ Memory Problems * ☐ Incoordination * \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   **FEMALES ONLY:**  Date Last Mammogram Normal Abnormal\_ Date last PAP Normal Abnormal\_ Age Onset Periods Age Onset Menopause Periods Regular? Yes No  Number Pregnancies |
| --- | --- | --- |

# SOCIAL HISTORY

## OCCUPATIONAL

Highest level of education completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current work status: ☐Working ☐ Student ☐ Unemployed ☐ Disabled ☐ Retired ☐ Other

What is/was your occupation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What kind of jobs have you had in the past?

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| --- |
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Have you filed for Social Security Disability? \_\_ No \_\_Yes If yes, what is the status? \_\_ Approved/Receiving SSD benefit \_\_Pending \_\_ Denied

**Legal**

Have you ever been arrested or had legal charges?\_\_ No \_\_Yes If yes, please describe:

|  |
| --- |
|  |

## Substance Use

Do you drink alcohol? \_\_Yes \_\_No If yes, how often do you drink?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How many drinks do you have? \_\_\_\_\_\_\_\_\_\_\_ Do you smoke cigarettes? \_\_Yes \_\_No If yes, how much do you smoke?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use recreational drugs? \_\_Yes \_\_No If yes, which?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_