**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) |
| --- | --- | --- | --- |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Have you ever been hospitalized for psychiatric reasons?** ☐No ☐Yes If yes, when/where?

|  |
| --- |

# 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  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**ALLERGIES**

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

|  |
| --- |
|  |

## 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?

|  |
| --- |
|  |

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?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_