PACFLORIDA

PSYCHOLOGICAL ASSOCIATES OF CENTRAL FLORIDA
Psychological, Neuropsychological, and Forensic Services

This questionnaire is for the purpose of getting to know you better in order to provide the best possible mental health services. Please complete this form as honestly and completely as possible. All information that you provide us will be confidential as required by state and federal law.

Your name_____ Today's Date _____

Name of patient (if not yourself) _____ Patient's Date of Birth _____

Address _____

Phone _____ Phone 2 _____ Email _____

Insurance Coverage
Insurance company name _____

Policy number _____ Group number _____ Phone _____

Name of primary insured _____ Primary's Date of Birth _____

EAP benefits? ☐ No ☐ Yes If yes: Authorization #: _____ # of visits_____ Start/End Dates _____

Who referred you to our practice? _____

Why were you referred to us? _____

What do you hope to gain from your visit(s)? _____

Have you benefitted from mental health treatment or an evaluation before? _____

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Remarried ☐ Engaged ☐ Widowed ☐ Cohabitating

What is your occupation? _____

If applicable, please tell us about your partner: Name _____ Age _____ Occupation _____
If you have children, please tell us their names and ages:

Name	Age	Gender	Name	Age	Gender

Who currently lives in your residence?

Name	Relationship	Gender	Age	Name	Relationship	Gender	Age

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In your own words, describe the current problems as you see them .

How long has this been going on? _____

What have you done to cope? Was it helpful?

Symptoms
Please check any symptoms or experiences that you have had **in the last month**

- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep
- ☐ Difficulty getting out of bed
- ☐ Not feeling rested in the morning

Average hours of sleep per night _____

- ☐ Persistent loss of interest in previously enjoyed activities
- ☐ Withdrawing from other people
- ☐ Spending increased time alone
- ☐ Depressed mood
- ☐ Feeling numb
- ☐ Rapid mood changes
- ☐ Irritability
- ☐ Anxiety
- ☐ Panic attacks
- ☐ Frequent feelings of guilty
- ☐ Avoiding people, places, activities or specific things
- ☐ Difficulty leaving your home
- ☐ Fear of certain objects or situations (i.e. flying, heights, bugs) Describe:_____
- ☐ Repetitive behaviors or mental acts (i.e. counting checking doors, washing hands)
- ☐ Outbursts of anger

- ☐ Worthlessness
- ☐ Hopelessness
- ☐ Sadness
- ☐ Helplessness
- ☐ Fear
- ☐ Feeling or acting like a different person

- ☐ Changes in eating/appetite
- ☐ Eating more
- ☐ Eating less
- ☐ Voluntary vomiting
- ☐ Use of laxatives
- ☐ Excessive exercise to avoid weight gain
- ☐ Binge eating
- ☐ Are you trying to lose weight?
- ☐ Weight gain _____lbs
- ☐ Weight loss _____ lbs

- ☐ Difficulty catching your breath
- ☐ Increase muscle tension
- ☐ Unusual sweating
- ☐ Easily started, feeling “jumpy”
- ☐ Increased energy
- ☐ Decreased energy
- ☐ Tremor
- ☐ Dizziness
- ☐ Frequent worry
- ☐ Physical sensations others don’t have
- ☐ Racing thoughts
- ☐ Intrusive memories
- ☐ Difficulty concentrating or thinking
- ☐ Large gaps in memory
- ☐ Flashbacks
- ☐ Nightmares
- ☐ Thoughts about harming or killing yourself
- ☐ Thoughts about harming or killing someone else

- ☐ Feeling as if you were outside yourself, detached, observing what you were doing
- ☐ Feeling puzzled as to what is real and unreal
- ☐ Persistent, repetitive, intrusive thoughts, impulses or images
- ☐ Unusual visual experiences such as flashes of light, shadows
- ☐ Hear voices when no one else is present
- ☐ Feeling that your thoughts are controlled or placed in your mind
- ☐ Feeling that the TV or radio is communicating with you
- ☐ Difficulty problem solving
- ☐ Dependency on others
- ☐ Inappropriate expressions of anger
- ☐ Difficulty or inability to say "no" to others
- ☐ Sense of lack of control
- ☐ Abusive relationship
- ☐ Concerns about your sexuality
- ☐ Difficulty meeting role expectations
- ☐ Manipulation of others to fulfill your own desires
- ☐ Self-mutilation / cutting
- ☐ Ineffective communication
- ☐ Decreased ability to handle stress
- ☐ Difficulty expressing emotions

Please describe any other symptoms or experiences you have had problems with:

Are you currently taking **PSYCHIATRIC** medication? ☐ No ☐ Yes If yes, please list:

Medication	Dosage	How long have you been taking it?

Have you been on **PSYCHIATRIC** medication in the **past**? ☐ No ☐ Yes If yes, please list:

Medication	Dosage	First/Last time you took it	Effect of Medication

Are you currently taking **NON**-PSYCHIATRIC medication? ☐ No ☐ Yes If yes, please list:

Medication	Dosage	How long have you been taking it?

Have you been hospitalized for **PSYCHIATRIC** reasons? ☐ No ☐ Yes If yes, please describe:

Hospital	Dates	Reason

Have you ever attempted suicide? ☐ No ☐ Yes If yes, please describe:

MEDICAL HISTORY

Are you CURRENTLY under treatment for any medical condition? ☐ No ☐ Yes If yes, please describe:

Please list any PRIOR illnesses, operations and accidents

FAMILY HISTORY

Father: Age: _____ ☐ Living ☐ Deceased Cause of death: _____
If deceased, HIS age at time of death _____ Your age at the time of his death:_____
Occupation: _____ Health:_____ Frequency of contact with him_____
Are you/Have you been close to him? _____

Mother: Age: _____ ☐ Living ☐ Deceased Cause of death: _____
If deceased, HER age at time of death _____ Your age at the time of her death:_____
Occupation: _____ Health:_____ Frequency of contact with her_____
Are you/Have you been close to her? _____

Brothers and Sisters

Name	Gender	Age	Whereabouts	Are you close to him/her?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

During your childhood, did you live any significant period of time with anyone other than your natural parents? ☐ No ☐ Yes
If yes, please give the person's name and relationship to you: _____

Please place a check mark in the appropriate box if these are or have been present in your relatives

	Children	Brothers	Sisters	Father	Mother	Aunt/Uncle	Grandpar-ents
Nervousness							
Depression							
Hyperactivity							
Psychiatric Medication							
Psychiatric Hospitalization							
Suicide Attempt or Death							
Sub-stance/Drinking problem							

SOCIAL HISTORY

Past Marital History
Have you been married previously? ☐ No ☐ Yes
If yes, When? _____ How long? _____ When? _____ How long? _____

Education
Highest grade level completed _____ Degree obtained, if applicable _____
Did you have any disciplinary problems in school? ☐ No ☐ Yes
If yes, please explain: _____
Were you considered hyperactive/ADHD in school? ☐ No ☐ Yes
If yes, please explain: _____
If yes, were you on any medication? ☐ No ☐ Yes
If yes, what medications? _____
What kinds of grades did you get in school? _____
Have you ever served in the military? ☐ No ☐ Yes
If yes, please briefly describe:

Type of discharge: _____

Employment
Are you currently employed? ☐ No ☐ Yes
If yes, employer's name:_____
What type of work do you do? _____
How many employers have you had in the past five years? _____

Have you been arrested? ☐ No ☐ Yes
If so, please describe: _____

Do you have a religious affiliation? ☐ No ☐ Yes
What kind of social activities do you participate in? _____
Who do you turn to for help with your problems? _____
Have you ever been abused?
☐ Verbally ☐ Emotionally ☐ Physically ☐ Sexually ☐ Neglected
Please describe:

SUBSTANCE ABUSE
Do you drink alcohol? ☐ No ☐ Yes If yes, age of first use: _____
How much do you drink? _____ How often do you drink? _____
Have you ever passed out from drinking? ☐ No ☐ Yes How often? _____
Have you ever blacked out from drinking? ☐ No ☐ Yes How often? _____
Have you ever had the "shakes?" ☐ No ☐ Yes How often? _____
Have you ever felt you should cut down on your drinking /drug use? ☐ No ☐ Yes
Have people annoyed you by criticizing your drinking/drug use? ☐ No ☐ Yes
Have you ever felt bad or guilty about your drinking/drug use? ☐ No ☐ Yes
Have you ever drank/used drugs in the morning to steady your nerves or relieve a hangover? ☐ No ☐ Yes
Do you use tobacco? ☐ No ☐ Yes If yes, how often? _____
Please indicate any other types of drugs you have used, how long and the last time you used.

Is there anything else you would like us to know about you?