

AEROSPACE PSYCHIATRY ASSESSMENT FORM

Fill out highlighted areas

Name		Date	
Birth Information			
Date of birth	Place of birth		Age
Ethnic Background			
Caucasian <input type="checkbox"/>	African American <input type="checkbox"/>	Asian American <input type="checkbox"/>	
Hispanic <input type="checkbox"/>	Native American <input type="checkbox"/>	Other <input type="checkbox"/>	
Gender		Marital Status	
Female <input type="checkbox"/>	Never married <input type="checkbox"/>	Widow/widower <input type="checkbox"/>	
Male <input type="checkbox"/>	Married <input type="checkbox"/>	Separated/Divorced <input type="checkbox"/>	
Education			
High school (circle one)		College/university (circle one)	
6 th or earlier	7 th 8 th	1 2 3 4	BA BS MA MS
9 th 10 th 11 th 12 th	5 Other	MBA Other	
Occupation			
Pilot : Airline and Employment Dates:			

Chief Complaint

DEPRESSION <input type="checkbox"/> _____	ANXIETY <input type="checkbox"/> _____
ATTENTION <input type="checkbox"/> _____	MEMORY <input type="checkbox"/> _____
ALCOHOL <input type="checkbox"/> _____	SUBSTANCE <input type="checkbox"/> _____
DUI <input type="checkbox"/> _____	LEGAL <input type="checkbox"/> _____

ANXIETY (circle)	None	Mild	Moderate	Severe
Generalized Phobias Panic Attacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OCD PTSD Acute Stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

DEPRESSION (5 of 9)	None	Mild	Moderate	Severe
1. Feeling down or depressed most of the day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Loss of interest/pleasure in most activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Significant change in weight or appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Sleeping too much or too little	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Restlessness or slowness observable by others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Difficulties in concentrating or making decisions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Blaming self too much and feeling worthless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Fatigue or loss of energy nearly every day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Thinking about death frequently	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MELANCHOLIC FEATURES (1 and/or 2)	Yes	<input type="checkbox"/>
10. Loss of pleasure in almost all activities		<input type="checkbox"/>
11. Loss of reactivity to pleasurable stimuli		<input type="checkbox"/>
And 3 of the following		
12. Distinct quality of depressed mood		<input type="checkbox"/>
13. Depression is worse in AM		<input type="checkbox"/>
14. Early morning awakening		<input type="checkbox"/>
15. Marked psychomotor retardation		<input type="checkbox"/>
16. Significant anorexia or weight loss		<input type="checkbox"/>
17. Excessive or inappropriate guilt		<input type="checkbox"/>
ATYPICAL FEATURES	Yes	<input type="checkbox"/>
18. Mood reactivity (and at least two of the following)		<input type="checkbox"/>
19. Significant weight gain or increased appetite		<input type="checkbox"/>
20. Hypersomnia		<input type="checkbox"/>
21. Leaden paralysis		<input type="checkbox"/>
22. Long standing pattern of rejection resulting in Social or occupational impairment		<input type="checkbox"/>
23. And , Criteria are not met for melancholic features		<input type="checkbox"/>
PAST PSYCHIATRIC HISTORY	None	<input type="checkbox"/>
24. Prior episodes of depression for at least 2 weeks		<input type="checkbox"/>
25. Most recent episode _____		
26. First episode _____		
27. Hospitalizations _____ Suicidal attempts _____		
MANIA	No	<input type="checkbox"/>
28. Ever felt with plenty of energy		<input type="checkbox"/>
29. Ever felt on top of the world		<input type="checkbox"/>
30. Ever gone on a spending spree		<input type="checkbox"/>
PSYCHOSIS	No	<input type="checkbox"/>
31. Ever heard voices other people couldn't hear		<input type="checkbox"/>
32. Ever seen things other people couldn't see		<input type="checkbox"/>
33. Ever felt that your life was in danger		<input type="checkbox"/>

Comments (Use number to identify question.)
Please circle: MELANCHOLIC / ATYPICAL / NONE

R/O Dysthymia: > 2 years of depression

PSYCHOTROPIC HISTORY (including herbal preparations, e.g., StJW, GB, G)					RESPONSE		
MEDICATION	DOSE	Freq	Start	Stop	None	Good	Excel
1					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Past Medical History:

Neurological: Head Injury, Parkinson's disease, Stroke, Seizure,
Cardiac: Hypertension, Heart Attack, Angina, CHF, Arrhythmias
Respiratory: Asthma, Emphysema, COPD
Endocrine: Thyroid disease, Diabetes

Cancer: Melanoma, Lung, Breast, Prostate
GI: Ulcer, Liver
Psychiatric: Prior Depression, Bipolar
Blood: Anemia, Leukemia, Bleeding disorder, Anticoagulant

CONDITION	DATES	COMMENTS	Stable
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>

FAMILY HISTORY	CONDITION
Father/ Mother/Siblings	

MEDICATION	Dose	Route & Freq	Start	Stop	Condition
1					
2					
3					

ALLERGIES	None
Substance	Reaction

REVIEW OF SYSTEMS	Anxiety	Somatic	HEIGHT _____ WEIGHT _____
34. General (Weight change, fever, fatigue)	<input type="checkbox"/>	<input type="checkbox"/>	BLOOD PRESSURE ____/____
35. Neurological (Headache, dizziness, weakness)	<input type="checkbox"/>	<input type="checkbox"/>	PULSE RATE _____ RESPIRATION _____
36. Head and neck (Hearing loss/aid, visual difficulties)	<input type="checkbox"/>	<input type="checkbox"/>	Right (R) or Left (L) Handedness _____
37. Respiratory (Shortness of breath, cough, wheezing)	<input type="checkbox"/>	<input type="checkbox"/>	
38. Cardiovascular (Chest pain, palpitations)	<input type="checkbox"/>	<input type="checkbox"/>	
39. Gastrointestinal (Nausea, constipation, diarrhea)	<input type="checkbox"/>	<input type="checkbox"/>	
40. Extremities (Claudication, edema, muscle cramps)	<input type="checkbox"/>	<input type="checkbox"/>	
41. Gait and joints (Arthritis, pain, falls, devices)	<input type="checkbox"/>	<input type="checkbox"/>	
42. Skin (Rashes, itching, swelling)	<input type="checkbox"/>	<input type="checkbox"/>	
43. Genitourinary (Urinary frequency, incontinence)	<input type="checkbox"/>	<input type="checkbox"/>	
44. GYN (Irregular menses, painful menses)	<input type="checkbox"/>	<input type="checkbox"/>	

SMOKING	Never	Comments (Use number to identify question.)
Packs per day: 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> Other <input type="checkbox"/>		
Age began: _____ years old <input type="checkbox"/> Quit: _____ years old		

ALCOHOL USE	None	CAGE
45. Average daily consumption (ounces) 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> Other <input type="checkbox"/>		
46. Ever told or felt you should cut down on drinking?	<input type="checkbox"/>	
47. Ever felt bad or guilty about your drinking?	<input type="checkbox"/>	
48. Ever drink first thing in AM to get rid of hangover?	<input type="checkbox"/>	

DRUGS OF ABUSE		None	<input type="checkbox"/>
49. Marijuana			
50. Cocaine/crack			
51. Other			
MENSTRUAL/PREGNANCY HISTORY			
52. Menopause age _____			
53. Last menstrual period date ____ / ____ / ____			
54. Gravida _____ Para _____ Abortion(s) _____			
MENTAL STATUS EXAMINATION			
GENERAL APPEARANCE AND BEHAVIOR			
Well-nourished	<input type="checkbox"/>	Well-developed	<input type="checkbox"/>
Attire			
Neat	<input type="checkbox"/>	Casual	<input type="checkbox"/>
Remarkable features		None	<input type="checkbox"/>
Abnormal movements		None	<input type="checkbox"/>
Abnormal posture		None	<input type="checkbox"/>
Attitude towards the examiner			
Casual	<input type="checkbox"/>	Cooperative	<input type="checkbox"/>
Eye contact		Good	<input type="checkbox"/>
Fair	<input type="checkbox"/>	Poor	<input type="checkbox"/>
MOOD AND AFFECT			
Euthymic			<input type="checkbox"/>
Affect			
Appropriate	<input type="checkbox"/>	Congruous	<input type="checkbox"/>
DEPRESSION			
Sad	<input type="checkbox"/>	Hopeless	<input type="checkbox"/>
Depressed	<input type="checkbox"/>	Worthless	<input type="checkbox"/>
COGNITION		Normal	<input type="checkbox"/>
Consciousness			
Clear	<input type="checkbox"/>	Somnolent	<input type="checkbox"/>
Voice		Normal	<input type="checkbox"/>
Orientation		Well-oriented	<input type="checkbox"/>
Person	<input type="checkbox"/>	Place	<input type="checkbox"/>
		Time	<input type="checkbox"/>
Memory		Intact	<input type="checkbox"/>
Immediate	<input type="checkbox"/>	Recent	<input type="checkbox"/>
		Remote	<input type="checkbox"/>
Fund of Information		Good	<input type="checkbox"/>
Fair	<input type="checkbox"/>	Poor	<input type="checkbox"/>
		Impaired	<input type="checkbox"/>
Intelligence (estimated)			
Superior	<input type="checkbox"/>	Average	<input type="checkbox"/>
High average	<input type="checkbox"/>	Below average	<input type="checkbox"/>
Above average	<input type="checkbox"/>	Retarded	<input type="checkbox"/>
THOUGHT CONTENT			
Perceptual Abnormalities		None	<input type="checkbox"/>
Ideas of reference	<input type="checkbox"/>	Phobias	<input type="checkbox"/>
Derealizations	<input type="checkbox"/>	Obsessive thoughts	<input type="checkbox"/>
Depersonalizations	<input type="checkbox"/>	Compulsive behaviors	<input type="checkbox"/>
Hallucinations		None	<input type="checkbox"/>
Visual	<input type="checkbox"/>	Gustatory	<input type="checkbox"/>
Auditory	<input type="checkbox"/>	Olfactory	<input type="checkbox"/>
Tactile	<input type="checkbox"/>		<input type="checkbox"/>

Contraceptive Method:

Auditory Hallucinations	None	<input type="checkbox"/>
One voice	<input type="checkbox"/>	Comment on actions <input type="checkbox"/>
Many voices	<input type="checkbox"/>	Command <input type="checkbox"/>
Delusions	None	<input type="checkbox"/>
THOUGHT PROCESS	Normal	<input type="checkbox"/>
Goal-directed	<input type="checkbox"/>	Disorganized <input type="checkbox"/>
ABSTRACT THINKING	Normal	<input type="checkbox"/>
JUDGMENT	Good	<input type="checkbox"/>
INSIGHT	Good	<input type="checkbox"/>
IDEATIONS: Suicidal /Homicidal	None	<input type="checkbox"/>

DOCUMENTS			
55. Blue Ribbon File		56. Cog Screen/ NeuroPsych	
57. Aftercare		58. AME/Medical	
59. Psychiatric		60. Other	

DIAGNOSTIC IMPRESSION (Check appropriate diagnosis)	
Diagnosis	<input type="checkbox"/>
	<input type="checkbox"/>
	<input type="checkbox"/>
Psychosocial/Contextual Factors	<input type="checkbox"/>
Disability - WHODAS	<input type="checkbox"/>

SUMMARY AND PLAN	
1. Evaluation & Counseling:	<input type="checkbox"/>
2. Psychotherapy:	<input type="checkbox"/>
3. Psychopharmacology:	<input type="checkbox"/>
4. Complementary: Nutrition – Exercise – Relaxation - Sleep	<input type="checkbox"/>
5. Anxillary Tests/Labs:	<input type="checkbox"/>
6. Consultations:	<input type="checkbox"/>
7. Follow-up:	<input type="checkbox"/>
8. Other	<input type="checkbox"/>
	<input type="checkbox"/>
	<input type="checkbox"/>

Gabriela Corá, MD, DFAPA, MHA, MBA _____ **Date** ____/____/____