Aviation Psychiatry
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UNDERSTANDING THE EVALUATION

My apologies in advance. This is a long form.

WHY THE LONG REGISTRATION?

Producing an FAA-compliant evaluation requires your psychiatrist to have a lot of information. The detailed registration serves several purposes. First, it will help me identify any complicating issues in your case that could be a barrier to medical certification.

The registration will also help identify the records we need to finish your evaluation; the lack of appropriate files is a predictable bottleneck to finishing my report.

Finally, I use the registration to act as a roadmap to the in-office assessment and writing your report. A thorough registration, done on your own time, will save you one to two hours of billed charges against your account. Please take your time and be thorough here. You will save money and I will write a more efficient report.

You can save even more money by doing the registration, with these same questions, fully online. You can find the online registration at:

https://www.aviationpsychiatry.com/registration

DISCLOSURES, FEES, AND BILLING

A disclosure agreement that covers some important rules about the evaluation must be signed at your appointment. You do not have to sign the disclosure to do the registration, but it's available for an advance review if you want to see it now.

The short summary of the disclosure is:

- A doctor-to-patient (i.e., treatment) relationship is not established in this evaluation.

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- Telling the truth, even when it feels damaging, is much better than trying to mislead me or leaving something out.
- A review of the legal, medical, and psychotherapy records is a key requirement for these evaluations.
- You have a right to disagree with the findings, but the appeal does not go through me.
- Who gets the report depends on the legal definition of "client," and the client is sometimes an employer instead of the pilot.

You can read the entire disclosure here:

https://www.aviationpsychiatry.com/disclosure

Fees and engagement pathways are discussed here:

https://www.aviationpsychiatry.com/fees

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DEMOGRAPHICS

First Name	
Last Name	
Email address	
Mailing Address	
City	
State	
Zip Code	
Preferred telephone	
Your birthday Month, Day, Year	
Is it okay to leave a voice mail?	
Is it okay to send you email?	
Who referred you to me?	

FAA INFORMATION

What is your issue with the FAA?

_____

_____

_____

Has the FAA given you a deadline?

☐ Yes (if yes, please list deadline:_____)
☐ No
☐ I'm not sure

Who is your aviation medical examiner (AME)?

Name: _____

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Street Address: _____

City, State, Zip: _____

If you have a current or past Medical Certificate, please list the Certificate Number and Medical Class (1, 2, or 3). This will make it more efficient to request your records.

_____

If you have ever had a pilot's medical certificate, have you, for any reason whatsoever, held a Special Issuance Authorization medical certificate?

☐ Yes
☐ No

Has the FAA ever taken any enforcement action, of any kind, against your medical certificate, pilot's license, or any of your ratings?

☐ Yes
☐ No

Look at the last letter that you received from the FAA. Please look for the PI# (which should be just under your name) and insert it below. If your letter doesn't have this number, or you don't have any correspondence from the FAA, please just put NONE.

_____

Now look for the MID# and insert it below. Again, if your letter doesn't have this number, or you don't have any correspondence from the FAA, please just put NONE.

_____

And, finally, look for the App ID# and insert it below. The same rule as above for "NONE" applies here, too.

_____

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If you have a letter from the FAA that specifically required a psychiatric evaluation, does the letter say anything about a requirement that your psychiatrist review the "complete airman medical file" before the evaluation? Please read all pages of the letter, if you have one, before you answer this question. Your evaluation will fail at the FAA if the psychiatrist was required to review the full file but did not do so.

☐ Yes
☐ No

MEDICAL HISTORY

Who is your primary care doctor?

Name: _____
Street Address: _____
City, State, Zip: _____

☐ I don't have a primary care doctor.

Have you been to any clinic, hospital, or emergency department for any reason in the last five years?

☐ Yes
☐ No

Who did you see when you last got medical care? You can put SAME for the next two questions if the last clinician you saw was your primary care provider.

Name: _____
Street Address: _____
City, State, Zip: _____

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Please list the reason for your last visit to a doctor.

_____

Have you had any other visits for medical care in the last five years?

☐ Yes
☐ No

If yes, please list the reason for your visit(s), and the name and address of all additional medical providers in the last five years.

_____
_____
_____
_____
_____
_____
_____
_____
_____

Use Appendix 1, at the end of the registration, if you need more room for medical information.

Have you ever been a medical or surgical inpatient?

☐ Yes
☐ No

If yes, please list the reason(s) for your inpatient visit.

_____

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When were you last admitted? It's faster to get records when you can be exact.

Date: _____

Name and Address of the Hospital

Name: _____
Street Address: _____
City, State, Zip: _____

Any other hospital admissions?

☐ Yes
☐ No

If yes, please list the reason for hospitalization, the dates, and the name and address of each hospital.

_____
_____
_____
_____
_____
_____
_____
_____
_____

Use Appendix 1, at the end of the registration, if you need more room for medical information.

Have you ever had an outpatient or day surgery/procedure of any kind?

☐ Yes

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☐ No

If yes, please list the procedure, dates (approximate if unknown), and the locations of your procedures.

_____

_____

_____

Have you ever had a concussion, been knocked unconscious, or had a blow to the head that caused severe headaches, ringing of the ears, nausea, vision changes, or any other significant symptom?

☐ No
☐ One time
☐ Twice
☐ A few times

What is your height?

_____

What is your weight? Guesses are okay.

_____

Please check all medical problems that apply to you.

☐	Hypertension (high blood pressure)
☐	High cholesterol or high lipids
☐	Diabetes
☐	Hepatitis
☐	Asthma
☐	Angina (cardiac chest pains)
☐	Heart attacks
☐	Strokes

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☐	Seizures
☐	Arrhythmia (irregular heart beat)
☐	Cancer
☐	Prostate problems
☐	Irregular periods
☐	Menopause
☐	Fibromyalgia
☐	Arthritis
☐	Thyroid disease
☐	Chronic pain, including headache
☐	Irritable bowel syndrome
☐	Other digestive problems
☐	Skin disease
☐	I don't have any medical problems

Thinking about how you feel over the last few days, or the last few weeks, have you been bothered by:

			If yes, what happens?
☐ ☐	Yes No	Above the neck complaints, like headaches, vision or hearing problems, dental problems.	
☐ ☐	Yes No	Complaints in the neck or chest, like congestion, wheezing, or some other breathing problem.	
☐ ☐	Yes No	Abdominal issues, like nausea, vomiting, cramping, diarrhea, or constipation.	
☐ ☐	Yes No	Upper or lower back problems.	

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☐ Yes ☐ No	Problems to bowel or bladder, like frequent urination, blood loss into the toilet.	
☐ Yes ☐ No	Problems with arms, legs, fingers, or feet.	
☐ Yes ☐ No	Problems with the blood system, like easy bruising or bleeding that won't stop.	
☐ Yes ☐ No	Skin problems, like rashes, lumps under the skin, suspicious skin blemishes.	

Are you allergic to any medications?

☐ Yes
☐ No

If yes, which medications? Also list what happens (rash, itching, hives, etc.)

_____

Please list all medications that you take by prescription, including the dosages and the reason you take the medication. Then, please list all over - the - counter medications, vitamins, herbal supplements, or other remedies that you take on occasion.

Drug or remedy	Dose	How often?	Reason

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MENTAL HEALTH AND USE OF SUBSTANCES

For any reason at all, have you ever seen a psychiatrist? if you're not sure if you met with a psychologist or psychiatrist, go ahead and reply "Yes"; answer "No" if your counselor was not a doctorate-level professional.

☐ Yes
☐ No

If yes, who is or who was the psychiatrist?

Name: _____
Street Address: _____
City, State, Zip: _____

Your diagnosis:

_____

If you were prescribed a medication, please list every medication with as much detail as you can remember.

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Have you ever seen any other psychiatrist? Only answer "Yes" if you have worked with a psychiatrist, not a counselor.

☐ Yes
☐ No

Please provide a brief summary which includes approximate dates of assessment or treatment, your psychiatrist's name, and the contact information.

Use Appendix 2, Additional Mental Health Information, if you need more room for this question.

Even if not by a psychiatrist, have you ever been prescribed a medication for anxiety, depression, insomnia, concentration problems, bipolar mood disorder, or any other mental health problem? *For example, did your primary care provider ever treat you for "nerves", "stress", or sleeping problems?*

☐ Yes
☐ No

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Have you ever been diagnosed with ADD or ADHD, or given medications for focus and attention (like Ritalin or similar drugs) by any doctor even if you were not diagnosed with ADD/ADHD?

☐ Yes
☐ No

For any reason at all, are you currently seeing a therapist or any kind of counselor?

☐ Yes
☐ No

If yes, who is the therapist?

Name: _____
Street Address: _____
City, State, Zip: _____

What problem are you trying to change?

_____

Are you currently seeing any *other* counselors of any kind? This would include school counselors, family counselors, or a court - ordered group or counseling session of any sort.

☐ Yes
☐ No

If yes, please tell me about what else you are working on with a counselor.

_____
_____
_____

Have you ever seen a counselor for any reason in the past?

☐ Yes

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☐ No

If yes, please tell me a bit about your previous counseling.

_____
_____
_____

Have you been a patient in a psychiatric hospital, an emergency department for psychiatric care, a detox facility, or residential rehabilitation center for addiction?

☐ Yes
☐ No

If yes, name of last psychiatric hospital, emergency department, detox center, or rehabilitation center.

Name: _____
Street Address: _____
City, State, Zip: _____

When were you admitted?

Date: _____

Other than the facility listed above, have you ever been admitted to any other psychiatric hospital, emergency department for psychiatric care, a detox facility, or residential rehabilitation center for addiction at any other time in your life?

☐ Yes
☐ No

If yes, list the full name of the facility and the approximate dates you were in treatment. Also, please tell me why you were there.

_____

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_____
_____
_____
_____
_____

Have you ever had any outpatient treatment, or have you ever attended a self-help group, for management of any concern with drugs or alcohol? Alcoholics Anonymous is one example of a self-help group

☐ Yes
☐ No

If yes, tell me about your outpatient treatment or self-help groups.

_____
_____
_____

Do you currently use alcohol?

☐ Yes
☐ No

Do you use any kind of tobacco product?

☐ Yes
☐ No

If yes, are you interested in quitting? There are several ways to get free help to become an ex-smoker. You can call the Quit Line, at 1 - 800 - QUIT - NOW. Web resources are available at the North American Quit Line at http://www.naquitline.org (if you live in Colorado go to https://www.coquitline.org).

Finally, the website http://www.smokefree.gov is packed with resources about getting help about how to quit.

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SOCIAL AND OCCUPATIONAL HISTORY

Where did you grow up?

_____

What is the highest level of education you have completed?

_____

Have you ever been in the military?

☐ Yes
☐ No

If you were in the military, did you ever face any scrutiny of any kind because of a behavioral problem, an emotional problem, or a concern or suspicion that involved drugs or alcohol?

☐ Yes
☐ No

If you answered yes to the question above, please describe each event and the outcome of any inquiry or investigation.

_____
_____
_____
_____
_____
_____

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Are you employed or have you been employed as a pilot?

☐ Yes
☐ No

Employment History, including military: list your jobs by giving the start date (Month/Year), the company, and your duties. Completing this in advance will help organize our discussion, save time, and increase accuracy. If you have an updated resume, it's probably easier to just give me a copy of it. If you want to do that, say "See Resume" in the field below and return a copy of your resume with the registration.

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LEGAL HISTORY

Have you had any legal problems? This includes arrests, convictions, deferred or suspended judgments, deferred or suspended sentences, actions against driving or flying privileges, or any other criminal action, or any action in civil or regulatory court. You must answer "Yes" even if charges were dropped, dismissed, or any record has been sealed or expunged. Moving violations do not count unless there was an action, of any kind, against your license.

☐ Yes
☐ No

Are you currently on probation or parole?

☐ Yes
☐ No

If yes, describe the legal problem leading to probation or parole.

_____
_____
_____

When will your probation/parole end?

Date: _____

Please list the name and contact information for your probation officer: Not the agency, the specific officer's name.

Name: _____
Street Address: _____
City, State, Zip: _____

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Have you ever been on probation or parole that has since ended? If there are multiple cases, please list the last that expired. You will have the option to provide detail on the other cases later.

☐ Yes
☐ No

If yes, please tell me about the other reason(s) for probation or parole.

_____
_____
_____

When did this probation/parole end?

Date: _____

Is there additional legal history to report?

☐ Yes
☐ No

Please describe all previous incidents with the best information you can provide (charges, dates, probation/parole officers, contact information)

_____
_____
_____
_____
_____
_____
_____
_____
_____

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LIFESTYLE

Do you have a spouse, partner, or are you otherwise in a committed relationship?

☐ Yes
☐ No

Do you exercise?

☐ Yes
☐ No

If yes, what kind of exercise do you like to do?

_____

How many times per week do you exercise?

_____

What sort of things make you happy?

_____
_____
_____

When you are under stress, what can you do that almost always helps?

_____
_____
_____

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ATTESTATION

By signing and dating below, I attest that I completed the registration fully and accurately, to the best of my ability.

A complete registration helps Dr. Kirk screen for disqualifying aeromedical events, guides the clinical interview, and can save the psychiatric time in writing the report. An incomplete registration will lengthen the clinical interview and increase the overall cost of the assessment.

Completing the registration does not on its own secure a client relationship with Dr. Kirk. The client relationship with Dr. Kirk is established only by requesting an appointment and paying the designated retainer fee.

Signed: _____

Print Name: _____

Date: _____

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PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

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GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(*For office coding: Total Score T*____ = ____ + ____ + ____)

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APPENDIX 1, ADDITIONAL MEDICAL INFORMATION

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APPENDIX 2, ADDITIONAL MENTAL HEALTH INFORMATION