Psychotherapy Associates of Tampa Bay L.L.C.™

EMOTIONAL SUPPORT ANIMAL (ESA) PSYCHOLOGICAL EVALUATION

Important Information

The primary purpose of an Emotional Support Animal (ESA) is to help his or her owner by decreasing symptoms that are associated with a mental/emotional disability and aid in coping, thereby improving overall functioning and well-being. The animal is not required to undergo any special training or be certified/registered by any formal association. An ESA is different from a therapy or service animal as federal law only applies when it concerns housing restrictions and/or airline travel. The ESA may not be brought into public places (with the exception of an airport). Should the animal in question be in poor health, not current on his or her vaccinations, a nuisance to others, or aggressive in any way, federal law does not apply.

Please note that Dr. Jessica L. Tommasi, LMHC ***will not provide ESA Letters of Prescription for anyone who requests one simply because he or she would like to keep a pet in what would otherwise be animal-restricted housing or wishes to travel with their pet only for convenience purposes***. This issue is taken very seriously, as many people attempt to take advantage of labeling their pet as an ESA to circumvent certain restrictions and laws. There must be a legitimate medical or mental/emotional reason (disability) why an individual is in true need of an ESA, such as a documented mental or psychological disorder (e.g., panic attacks, depression, Bipolar Disorder, PTSD, etc.). The individual must have a functional impairment in one or more of the following major life activities: walking, concentrating, hearing, self-care, performing manual tasks, social interaction, sleeping, seeing, hearing, speaking, breathing, learning, working, etc.

****Please do not assume that having an evaluation automatically makes you automatically eligible to receive an ESA Letter of Prescription, as Dr. Tommasi may find that you do not qualify for the reasons which will be discussed with you at the time of your appointment.***

*****Please be aware that while Dr. Tommasi may determine that you qualify for an ESA once your evaluation is conducted, she cannot be held responsible should your condominium association, HOA, landlord, leasing office, property manager, airline, etc. not legally comply by accommodating your disability.***

I have read the aforementioned and fully understand and consent to Dr. Tommasi's policies.

Patient Signature Date

PART I: PERSONAL INFORMATION

FIRST NAME_____ LAST NAME_____

EMAIL_____ PHONE #_____

STREET
ADDRESS_____

CITY/STATE_____ ZIP_____

GENDER: _____MALE _____FEMALE _____TRANSGENER

MARITAL STATUS: _____MARRIED _____SINGLE _____DIVORCED _____WIDOWED

PREFERRED ANIMAL: _____DOG _____CAT _____OTHER (PLEASE SPECIFY TYPE)

DESIRED PRESCRIPTION(S) _____ AIRLINE ONLY _____HOUSING ONLY _____BOTH

Please answer the questions contained in this questionnaire as honestly and in as much detail as possible, while keeping in mind how an Emotional Support Animal will help to reduce the symptoms associated with your disability and assist you with performing your activities of daily living.

PART II: GENERAL MENTAL AND PHYSICAL HEALTH

Question 1: Major Life Events

Sometimes major life events may contribute to symptoms similar to a psychological illness. Please list any major life events that have been a significant source of stress or anxiety in your life during the last year. Examples may include: death of a family member or other loved one, relationship problems (divorce, break up with a significant other), financial problems, loss of employment or housing, or ANY event that has been a major source of stress. Please provide as much information as possible.

Question 2: Emotional Symptoms

In the past year, have you experienced any significant external emotional symptoms such as crying, trembling, shortness of breath, headaches, or any other negative emotional symptoms? **Please provide as much information as possible and give approximate dates, locations, and circumstances if possible.**

Question 3: Major Impact on Life Activities

Are there one or more major life activities that you are unable to perform (or have great difficulty performing) because of problems caused by stress or any other emotional problem? Major life activities may include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, working, and driving.) _____YES _____NO

If you answered YES above:

(1) Please list the major life activities you are unable to perform or have difficulty performing and how you feel it has been affected by your emotional problems.

(2) For how long has this been occurring? Please list approximate dates and **provide as much information as possible.**

Question 4: General Medical History

Please list ANY illness (physical or psychological) that you have been diagnosed with by a medical professional. If NONE, then please indicate below.

Illness/Diagnosis Approximate Dates

Question 5: Medications

Please list any medications you are currently taking (both prescription and over the counter), including dosage and the prescribing physician (if applicable).

Question 6: General Physical Health

How would you describe your general physical health in the last 12 months? Have you suffered from ANY major physical ailments including, but not limited to, heart problems, cancer, diabetes, stroke, organ failure, broken bones, head trauma, fever, seizures, etc?

PART III: DRUG AND ALCOHOL USE

Similar to how major life events sometimes contributing to psychological symptoms, so may the use of illegal substances and/or excessive alcohol consumption. To better understand your current mental health condition, please provide the following information.

Question 7: Alcohol Use

If you have consumed alcohol in the past 12 months, please list the frequency and amount consumed. If none, please note that below.

Question 8: Illicit Drug Use

If you currently use any drugs, or have done so in the past, please identify the substance, frequency of use, and amount used. **If none, please note that below**.

PART IV

Please write complete answers when requested and indicate YES or NO to all questions or write "UNSURE" if you do not know.

Question 9: Have you ever been exposed to a traumatic event in which your life or someone's life was actually in danger or you thought your life or someone else's life was in danger? If yes, please describe what happened and provide as much information about the threat **AS YOU ARE COMFORTABLE** providing. **If no, please skip to PART V.** _____YES _____NO

Question 10: Did you experience feelings of intense fear or helplessness during or following the event? _____YES _____NO

Question 11: Have you experienced recurrent unwanted thoughts, dreams, or images? _____YES _____NO

If yes, please describe those you have been experiencing for the past 6 months and include how often they occur.

Question 12: Have you ever had flashbacks or feelings you were reliving the traumatic event even while you are awake? If yes, please explain. _____YES _____NO

Question 13: Do you have intense feelings of distress or anxiety when reminded of the traumatic event? If yes, please explain. _____YES _____NO

Question 14: Do you try to avoid people or places that remind you of the traumatic event? If yes, please explain. _____YES _____NO

Question 15: Do you try to avoid conversations or thoughts that remind you of the traumatic event? _____YES _____NO

Question 16: Since the traumatic event, have you been more alert or looking out for possible trouble? _____YES _____NO

Question 17: Since the traumatic event took place, have you had difficulty concentrating? _____YES _____NO

Question 18: Since the traumatic event took place, have you felt irritable or had outbursts that you had difficulty controlling? _____YES _____NO

Question 19: Since the traumatic event, do you have difficulty sleeping? _____YES _____NO

Question 20: Since the traumatic event, are you less interested in activities you previously enjoyed, have difficulty meeting new people and socializing? _____YES _____NO

Question 21: Do reminders of the traumatic event cause physical symptoms of distress, such as trembling, shortness of breath, increased pulse, muscle aches or sweating?
_____YES _____NO

Question 22: Do you believe your future may be negatively impacted as a result of the traumatic event you experienced? _____YES _____NO

Question 23: Since the traumatic event, have you had difficulty showing emotions or love or affection?
_____YES _____NO

Question 24: In the last 90 days, how often have you been bothered by your emotions/symptoms from the traumatic event? Please circle your answer: Rarely, Moderately, Often, Very Often, Other_____.

Question 25: Do the unwanted thoughts or feelings related to the traumatic event interfere with any major life activity? **Major Life Activities may include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communication, and working**.

(1) If yes, please specify which activities you are unable to perform or have difficulty performing and how you feel it has been affected by the unwanted thoughts or feelings related to the traumatic event.

(2) For how long has this been an issue? Please list approximate dates and provide as much information as possible.

PART V

Please write complete answers when requested and indicate either YES or NO to all questions or write "UNSURE" if you do not know.

Question 26: During the past 6 months, have you been frequently worried about big and/or small events in your life? _____YES _____NO (**If your answer is NO, please skip to PART VI.)**

If you answered YES to the above question, how frequently has your worrying caused anxiety or stress in the last 6 months? On a daily basis (MORE FREQUENTLY), several times each week (FREQUENTLY), only a few times each month or less (SOMETIMES), or NEVER. Please circle your answer.

If you answered YES to Question 26, please describe what kind of events you worry about and what happens to you when you worry. Please provide as many details as possible.

Question 27: Do people ever say you worry too much? _____YES _____NO

Question 28: Do you think you worry about things too much? ? _____YES _____NO

Question 29: Do you have difficulty controlling your worries or anxiety? _____YES _____NO

Question 30: How long have you had difficulty controlling your worries in the past 12 months?

_____ Less than 30 Days

_____1 -3 Months

_____ 3 – 6 Months

_____ Over 6 Months

Question 31: When worried, do you frequently feel irritable or on edge for no apparent reason?
_____YES _____NO
Question 32: Do you often worry something bad is going to happen to you or someone close to you?
_____YES _____NO

Question 33: When worried, do you typically have trouble sleeping? _____YES _____NO

Question 34: When worried, do you experience tension or muscle aches? _____YES
_____NO

Question 35: Do you often become tired easily or experience a sudden loss of energy?
_____YES _____NO

Question 36: Does your worrying interfere with your daily functioning? _____YES
_____NO

If you answered YES above, please explain how your worrying interferes with your daily functioning. **Please provide as many details as possible.**

PART VI

Please write complete answers when requested and indicate either YES or NO to all questions or write "UNSURE" if you do not know.

Question 37: Have you ever experienced sudden and unexpected intense fear or anxiety for no apparent reason (panic attack) or in situations where you did not expect it to occur in the past 6 months? -
_____YES _____NO (**If your answer is NO, please skip to PART VII.)**

Question 38: If you answered YES to the above question, how often do these anxiety attacks occur?

_____On a daily basis

_____ Several times a week

_____ A few times a month

_____ Other

Question 39: If you answered YES to Question 37, please describe your most recent panic attack. What happened? Please provide detailed information pertaining to emotional and physical reaction, time and place, and situation.

Question 40: Do you often worry that these panic attacks will have negative health consequences, such as a possible heart attack, loss of control, or any other debilitating affect(s)?
_____YES _____NO

Question 41: Do you worry that you will experience more panic attacks in the future?
_____YES _____NO

Question 42: During your last panic attack, did you feel your pulse increase (e.g., increased heart rate)?
_____YES _____NO

Question 43: During your last panic attack, did you experience uncontrollable shaking or trembling?
_____YES _____NO

Question 44: During a panic attack, do you ever feel dizzy or nauseous? _____YES
_____NO

Question 45: During your last panic attack, did you have difficulty breathing or feel like you were out of breath? _____YES _____NO

Question 46: During your last panic attack, did you experience hot flashes or profuse sweating?
_____YES _____NO

Question 47: During your last panic attack, did any of your extremities (e.g., legs, fingers, toes, etc.) feel numb or cold? _____YES _____NO

Question 48: During your last panic attack, did you feel detached from reality, almost as though you were dreaming? _____YES _____NO

Question 49: Do your panic attacks or fear of future panic attacks interfere with your daily functioning and cause you to purposely avoid certain situations, activities and/or places?
_____YES _____NO

If you answered YES, please explain how your panic attacks interfere with your daily life activities. Please provide as much detailed information as possible.

PART VII

Please write complete answers when requested and indicate either YES or NO to all questions or write "UNSURE" if you do not know.

Question 50: Do you have an intense fear that you will do or say something in front of others that will embarrass you? _____YES _____NO (**If your answer is NO, please skip to PART VIII.)**

Question 51: If you answered YES to the question above, please describe specifically what activity(ies) you are afraid of performing in front of other people that causes intense fear or anxiety. Please provide as many details as possible.

Question 52: Does your fear in Question 50 cause you intense stress or anxiety?
_____YES _____NO

Question 53: Before, during, or immediately after the feared activity in Question 50 is performed, does it make the task extremely difficult to complete? _____YES _____NO

Question 54: Have you ever completely avoided the activity, situation or place, making the task extremely difficult to complete? _____YES _____NO

Question 55: Do you think you are more afraid or worried than you should be?
_____YES _____NO

Question 56: Does the feared activity interfere with your daily functioning?
_____YES _____NO

Question 57: Does the feared activity interfere with your daily life activities?
_____YES _____NO

If you answered YES, please explain how this activity interferes with your daily life activities. Please provide as much detailed information as possible.

PART VIII

Please write complete answers when requested and indicate either YES or NO to all questions or write "UNSURE" if you do not know.

Question 58: Do you often feel sad or depressed for unknown reasons?
_____YES _____NO

Question 59: If you answered YES to the above question, how often have you felt sad or depressed in the last 30 days?

_____On a daily basis

_____ Several times a week

_____ A few times a month

_____ Other

Question 60: On a typical day, how long do your feelings of sadness or depression last?

_____ Less than 1 hour

_____ 1 to 3 hours

_____ 3 to 5 hours

_____ Greater than 5 hours

_____ None of the above

Question 61: Has your depression or sadness caused significant changes in appetite, causing you to eat significantly more or less? _____YES _____NO

Question 62: If you answered yes to the above question, in the last 3 months, how long has your appetite been increased or decreased?

_____ One week or less (Very Mild)

_____ 1 to 2 weeks (Mild)

_____ 2 weeks to 1 month (Moderate)

_____ More than 1 month (Severe)

Question 63: Has your depression or sadness caused you to lose a significant amount of weight (greater than 5%) in any given month? _____YES _____NO

Question 64: Have you lost interest in activities you previously enjoyed because of your depression of sadness? _____YES _____NO

Question 65: If you answered YES to the above question, in the last 3 months, for how long has your disinterest in previously activities of interest persisted?

_____ One week or less (Very Mild)

_____ 1 to 2 weeks (Mild)

_____ 2 weeks to 1 month (Moderate)

_____ More than 1 month (Severe)

Question 66: Do you often experience feelings of worthlessness or low self-esteem?
_____YES _____NO

Question 67: If you answered yes to the above question, in the last 3 months, how long has your have you been experiencing feelings of worthlessness or low self-esteem?

_____ One week or less (Very Mild)

_____ 1 to 2 weeks (Mild)

_____ 2 weeks to 1 month (Moderate)

_____ More than 1 month (Severe)

Question 68: Do you have difficulty sleeping or sleep too much? If so, in the last 3 months, how often do you experience sleeping problems?

_____On a daily basis

_____ Several times a week

_____ A few times a month

_____ Other

Question 69: Do you often feel fidgety or have problems sitting still? _____YES _____NO

Question 70: Do you often feel fatigued or suffer from an unusual loss of energy or motivation?
_____YES _____NO

Question 71: Do the unwanted feelings of sadness or depression interfere with your daily functioning or any major life activity? _____YES _____NO

If you answered yes above, please explain in detail what way(s) the depression of sadness has interfered with your daily life?

Question 71: Do you ever fluctuate between periods of feeling sadness or depression and high energy, elated, irritable or euphoric mood? _____YES _____NO

If you answered yes above, please explain in detail how these mood swings have interfered with your daily life? Please be sure to discuss their frequency, affect on decision-making, and other significant characteristics of these moods.

Thank you very much for taking the time to complete this questionnaire.