NEW BRAUNFELS PSYCHIATRY

Richard Senysyzn, MD
Psychiatry for Adults
1260 River Acres Dr
New Braunfels, TX 78130
830-730-5920, Fax. (888) 972-3955

Psychiatric Evaluation Intake Form

Patient Contact Information

Patient Name: _____ Date of Birth: _____ Age: _____
Last First MI

Address: _____

Contact phone number: _____ Email address: _____

Emergency Contact/Number/Relationship:_____

Primary Care Physician: _____Tel: _____Referred here by: _____

Reason For Your Visit: _____

_____

MD NOTES:

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Depression/Mania/Eating/PTSD/Panic/GAD/OCD/PD/Substances

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Previous Treatment

Please list any inpatient mental health hospitalization Hospital name/dates/reason

_____

_____

_____

Have you ever attempted to harm/kill yourself? If so, please list the occurrences below:

_____

Previous Outpatient Psychiatric History: Have you ever been treated for any of the following by either a family doctor or psychiatrist (check all that apply), if so, please list medications given:

_____ Depression _____ ADHD _____ Bipolar (Manic / Depressive) Disorder
_____ Anxiety _____ OCD _____ Schizophrenia
_____ Panic Attacks _____ PTSD _____ Alcohol Problems (including AA)
_____ Anorexia/ Bulimia _____ Binge-eating _____ Drug Problems _____ ECT treatment

Current and Previous MEDICAL Problems (Check all that apply

_____High Blood Pressure _____Diabetes _____Heart Attacks _____Strokes _____ Hepatitis
_____Asthma _____Thyroid _____Sleep Apnea _____COPD _____Seizures
_____Sexual Disease _____Heart Failure _____Hepatitis _____HIV _____Fibromyalgia
_____Hysterectomy _____Tubal Ligation _____Migraines _____Urinary _____Cancer
_____Bleeding Problems _____GI Problems _____Head Injury _____Kidney _____Cholesterol

MD Notes

_____

_____

_____

List all prior surgeries and hospitalizations for MEDICAL illnesses

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_____

_____

_____

Please List all current medications below (include birth control pills, over the counter medication and herbal remedies (i.e. decongestants, St. John's Wort etc)

1. _____ 4. _____ 7. _____ 10. _____
2. _____ 5. _____ 8. _____ 11. _____

Allergies (Medication/Food):

_____

Family History: Has anyone in your family ever been treated for any of the following (please check all that apply and when appropriate indicate paternal or maternal)

	Father	Mother	Aunt	Uncle	Brother	Sister	Children	Grandparent
Depression								
Anxiety								
Panic Attacks								
Post-traumatic stress								
Bipolar/Manic depression								
Schizophrenia								
Alcohol Problems								
Drug problems								
ADHD								
Suicide attempts								
Psychiatric hospital stay								

What MEDICAL Problems run on one or both sides of the family? (Diabetes, High Blood Pressure, etc)

_____

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Do You Smoke or Use Tobacco Products? _____

When was your last alcoholic drink?_____

In the past 30 days, about how many of those days have you had at least one alcoholic drink? _____

What is the maximum number of drinks you have had in one day in the past month? _____ drinks

_____ DUI _____ DWI _____ Public Intoxication _____ Seizures _____ DT's

]=

Please check the appropriate boxes that apply to you for the following substances:

	Never Used	Age first used	Last used on this approx date	Age peak use	Hx abuse?	Current use and frequency
Cocaine						
Amphetamine Or Speed						
Marijuana						
Diet Pills						
Hallucinogens (LSD,mushrooms, Mescaline)						
Ecstasy						
Diuretics						
Tranquilizers						
Pain Pills						
Inhalants						
Sleeping Pills						
Laxatives						
Cigarettes,cigars, Or tobacco						
PCP or Angel Dust						
IV Drug use						
Heroin						
GHB						

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Anabolic Steroids						
Caffeine(coffee, Tea, cola's, iced tea						
Benzodiazepines (xanax, valium, ativan Restoril, Librium)						
Other:						

Are you allergic to any medication or food? If so, please list below

_____

_____

Last menstrual period (if applicable) _____

Contraceptive method: _____

Pharmacy: _____ Phone #: _____

1. **Current marital status (Check one): ☐ Single, never married ☐ Married, living together ☐ Separated ☐ Widowed ☐ Cohabiting with partner ☐ Divorced**
2. **Total number of marriages? _____ How many children do you have? _____**
3. **Spouse's/Partner's Name:** _____
4. **Who else lives with you?** _____
5. **How many years of formal education have you completed (years)? _____**

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6. Highest degree obtained: (Check only one)

☐ High school graduate ☐ G.E.D. ☐ 4 year college degree ☐ M.B.A./M.A./M.S./M.P.H. ☐ M.D.

☐ Junior college degree or technical school diploma ☐ J.D./LL.B. ☐ Ph.D ☐ Other _____

7. What best describes your current employment status? (Check one from each category a, b, & c)

a. Employment Status	**b. Student Status**	**c. Volunteer Status**
☐ Unemployed, not looking for employment	☐ Part-time	☐ Volunteer Part-time
☐ Unemployed, not looking for employment	☐ Part-time	☐ Volunteer Full-time
☐ Full-time employed ☐ Part-time employed	☐ Not a student	☐ No Volunteer Work
☐ Retired ☐ Self-employed		
☐ On welfare ☐ Social security disability		

8. What is your occupation? _____

9. Current Residence

☐ Own my house/ condo ☐ Retirement Complex/Senior Housing ☐ RENTING

☐ Apartment /Condominium

10. What is your spouse's occupation? _____