NEW BRAUNFELS PSYCHIATRY

Richard Senyszyn MD
Claire Coco MD
1282 Common Street
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/Psychosis/Eating/PTSD/Panic/GAD/OCD/PD/Drugs*

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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

MD Notes

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_____

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

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Patient name_____

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List all prior surgeries and hospitalizations for MEDICAL illnesses

_____

_____

_____

Last menstrual period (if applicable) _____

Contraceptive method: _____

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. _____

Pharmacy: _____ **Phone #:** _____

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								
	Father	**Mother**	**Aunt**	**Uncle**	**Brother**	**Sister**	**Children**	**Grandparent**
Drug Problems								
ADHD								

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Suicide Attempts								
Psychiatric Hospital Stay								

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

_____

_____

Substance Use

Do You Use Tobacco Products? (Packs/amount per day)_____

When was your last drink with alcohol?_____

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 _____Blackouts _____AA/NA Meetings _____Detox/Rehab?

Please check if you have EVER used any of the below substances:

_____Marijuana _____Cocaine _____IV Drugs _____Xanax (Ativan, Valium, Benzodiazepines

_____Amphetamine _____Heroin _____PCP _____Hallucinogens (LSD, Mushrooms)

_____Ecstacy _____Pain Pills _____GHB _____Anabolic Steroids

_____Inhalants _____Diet Pills _____Diuretics _____Sleeping Pills

_____Tranquilizers _____Laxatives _____Caffeine

MD NOTES:

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Social History:

1. **Where were you born and raised?**_____
2. **Problems with developmental milestones?**_____
3. ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed** ☐ **Separated**
4. **Total number of marriages?** _____ **How many children do you have?** _____
5. **Housing:** ☐ **House** ☐ **Apartment** ☐ **With Friends** ☐ **With Family** ☐ **Homeless**
6. **Who lives with you?** _____
7. **Highest degree obtained and other training:**

☐ High school graduate ☐ G.E.D. ☐ 4 year college degree ☐ Graduate School

☐ Junior college degree or technical school diploma ☐ Military ☐ Honorable Discharge?

8. **What best describes your current employment status? (Check all that apply)**

a. Employment Status	**b. Student Status**	**c. Volunteer Status**
☐ Unemployed, looking for employment	☐ Full-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	☐ Disability	

9. **What is your occupation?** _____
10. **What do you do for exercise (and frequency)?**_____
11. **Type of diet?**_____
12. **Support system:**_____
13. **Hobbies:**_____
14. **History of physical/sexual abuse:**_____
15. **Have you ever been in jail or prison (and reason)?**_____

MD NOTES:

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Patient name_____

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Review of Systems: (please circle all that apply)

General : Recent weight loss, recent weight gain, weakness, fatigue, night sweats, fevers

Eyes : Double vision, blurred vision

Ears, nose, throat: Dry mouth, hoarseness or other voice change, difficulty swallowing

Respiratory: Cough, sputum (color: _____ ; quantity _____), shortness of breath at rest, shortness of breath with activity

Cardiovascular: Heart trouble, chest pain or discomfort, palpitations, shortness of breath while lying flat, swelling in legs or ankles

Gastrointestinal: Ulcer, trouble swallowing, heartburn, change in appetite, nausea, diarrhea, constipation, rectal bleeding or dark or tarry stools

Urinary: Increased frequency of urination, incontinence, reduced caliber or force of urinary stream,hesitancy, dribbling

Musculoskeletal: Muscle or joint pain or stiffness, joint pain, redness, swelling

Psychiatric: Anxiety, depression, changes in mood, thoughts of suicide

Neurologic: Headaches, dizziness, vertigo, fainting, blackouts, seizures, weakness, paralysis, numbness or loss of sensation, tingling or “pins and needles,” tremors or other involuntary movements, seizures

MD NOTES:

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Patient name_____