RESILIENT MIND PSYCHIATRY
8701 Shoal Creek Blvd, Suite 404
Austin, Texas 78757
Phone: (512) 572-5340
Fax: (512) 229-0830

NEW PATIENT EVALUATION REQUEST FORM

Notice: Completion of this form does not guarantee establishment of an appointment nor does it create a physician-patient relationship.

Today's Date_____

Name_____

Date of Birth_____

Gender _____ **Age** _____

Marital Status_____

Employment Status_____

Address_____

City_____**State**_____ **Zip Code**_____

Best phone number _____

☐ Okay to leave message with detailed information

☐ Leave message with call-back number only

Alternative phone number: _____

☐ Okay to leave message with detailed information

☐ Leave message with call-back number only

Email address: _____

Preferred pharmacy _____

Pharmacy Address_____

Pharmacy Phone _____Fax_____

Emergency contact _____

Relationship_____

Phone _____ Fax _____

Referred by _____

Phone _____ Fax _____

Primary care physician_____

Phone _____ Fax _____

RESILIENT MIND PSYCHIATRY
8701 Shoal Creek Blvd, Suite 404
Austin, Texas 78757
Phone: (512) 572-5340
Fax: (512) 229-0830

What are the concerns for which you are seeking psychiatric care?

What are your current stressors?

- ☐ Health issues
- ☐ Difficulty with abstinence from drugs and/or alcohol
- ☐ Difficulty sleeping
- ☐ Recent trauma
- ☐ Difficulty with stress reduction or relaxation
- ☐ Conflicting interpersonal relationships
- ☐ Financial
- ☐ Employment
- ☐ Legal

Please list all **psychiatric and/or substance use conditions** you have been diagnosed with.

	Diagnoses	Who diagnosed you?
1.		
2.		
3.		
4.		
5.		

Please list all **medical conditions** you have been diagnosed with.

	Diagnoses	Who diagnosed you
1.		

RESILIENT MIND PSYCHIATRY
8701 Shoal Creek Blvd, Suite 404
Austin, Texas 78757
Phone: (512) 572-5340
Fax: (512) 229-0830

2.		
3.		
4.		
5.		

ALL CURRENT MEDICATIONS (Please list all your medication including over the counter medication and supplements).

	Name of the Medication	Dosage	Frequency	Prescribed by
1.				
2.				
3.				
4.				
5.				

Have you taken psychiatric medications in the past?

	Name of the Medication	Dosage	Frequency	Side effect
1.				
2.				
3.				
4.				
5.				

Are you allergic to medication?

_____

_____

Are you currently in therapy or have you been in therapy in the past?

_____

_____

Have you ever been hospitalized for psychiatric reasons?

Hospitalization	Year	Reason for hospitalization

RESILIENT MIND PSYCHIATRY
8701 Shoal Creek Blvd, Suite 404
Austin, Texas 78757
Phone: (512) 572-5340
Fax: (512) 229-0830

1.		
2.		
3.		
4.		
5.		

Have you ever been in an intensive outpatient program or partial hospitalization program?

IOP/PHP	Year	Reason
1.		
2.		
3.		
4.		
5.		

Do you currently drink alcoholic beverages? If so, please provide type, amount, and frequency of usage (daily, weekly, or monthly)

_____

_____

Do you currently use any tobacco products? (Smoke/Chew/Other) If so, please provide type, amount, and frequency of usage

_____

_____

Have you ever been in an inpatient or outpatient detox or rehab for alcohol/drug/substance?

Detox/Rehab	Year	Substance
1.		
2.		
3.		
4.		
5.		

RESILIENT MIND PSYCHIATRY
8701 Shoal Creek Blvd, Suite 404
Austin, Texas 78757
Phone: (512) 572-5340
Fax: (512) 229-0830

Have you ever attempted to take your own life? If so, please list all attempts, reason, method, and outcome

_____

_____

Have you ever tried to hurt yourself without intending to take your own life?

_____

_____

Please call 911 and/or present to the nearest emergency room should you intend to act on suicidal or homicidal thoughts.