Buckeye Psychiatry, LLC

Demographic Sheet

Client's Name: _____

DOB: _____

Legal Guardian's Name if Applicable: _____

Address: _____

City: _____

Zip Code: _____

Home Phone Number: _____

Cell Number: _____

Email Address: _____

Preferred Method of Contact: Home Cell

Is it Okay to Leave a Message? Y N

Emergency Contact: _____

Relationship to You: _____

Emergency Contact Phone Number: _____

Consent for Treatment

By signing below, you are stating that you have read, understand and accept the office policies and have had the opportunity to have any questions answered. You are authorizing and requesting psychiatric assessment and treatment.

_____	_____
Name of Client (please print)	**Name of Legal Guardian (if applicable)**
_____	_____
Signature of Client or Legal Guardian	**Date**
_____	_____
Adam Brandemihl, M.D., D.A.B.P.N.	**Date**

Board Certified Psychiatrist

Sole Member, Buckeye Psychiatry, LLC

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PSYCHIATRIC INTAKE FORM

(Please note: If you are not comfortable answering any of the following questions feel free to leave the space blank)

Name:

_____

Today's date:

_____

Psychiatric History

What problem brings you here?

_____
_____
_____
_____
_____

When did it start?

_____
_____

Are the symptoms constant or intermittent?

_____
_____

Have you sought psychiatric care before and if so, who treated you?

_____
_____

Have you ever seen a counselor or therapist and if so who treated you?

_____

Have you ever been hospitalized psychiatrically? If so when and where?

_____
_____

Have you ever attempted suicide? If so when and how?

_____
_____

What, if any, mental or psychological conditions have you previously been diagnosed with?

_____

Do you have a history of self mutilation?

_____

_____

Have you ever received ECT (shock treatments)?

_____

What psychiatric medications have you tried in the past and how well did they work for you?

Med	Response/Side Effects

1._____

2._____

3._____

4._____

5._____

6._____

7._____

Medical History

What medical problems do you have?

_____

_____

_____

_____

_____

Who is your primary care doctor?

_____

Have you ever had a seizure or a traumatic brain injury?

_____

Do you have any prescription drug allergies?

_____

What medical and psychiatric meds are you currently on? (Please include dosing and schedule)

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

7. _____ 8. _____

9. _____ 10. _____

Family History

Do any medical illnesses tend to run in the family? If so what diseases/illnesses?

Relative	Disease/Illness
1.	
2.	
3.	
4	

Have any family members ever suffered from mental illness including alcohol or drug use?

Relative	Condition
1.	
2.	
3.	
4.	

Have any family members attempted or completed suicide? If so, who?

_____

_____

Background

Where were you born?

_____

Who were you raised by?

_____

What is your parent's marital status?

_____

How many siblings do you have?

_____

What is your marital status?

_____

If you are not married are you dating?

_____

If you are a woman is there any chance you are currently pregnant? What birth control method do you use?

_____

_____

How many children do you have?

_____

Who do you turn to for emotional support?

_____

_____

What are your current living arrangements? Who do you live with?

_____

What is the highest educational level you completed?

_____

Where are you currently employed?

_____

Have you ever had any legal problems? If so what type?

_____

_____

Do you have a history of violent behavior?

_____

Do you have access to firearms?

_____

Have you ever been a victim of any form of abuse (physical, emotional or sexual)? Who was the perpetrator?

_____

_____

What hobbies or activities do you enjoy?

_____

Do you have any religious preferences?

_____

Substance History

Have you ever abused or been dependent on any drugs including alcohol?

_____

Drug	First used	Last used	Highest amnt used	Current amnt used

Other Notes or Information: