



## 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.

_____	_____
<b>Name of Client (please print)</b>	<b>Name of Legal Guardian (if applicable)</b>
_____	_____
<b>Signature of Client or Legal Guardian</b>	<b>Date</b>
_____	_____
<b>Adam Brademihl, M.D., D.A.B.P.N.</b>	<b>Date</b>
<b>Board Certified Psychiatrist</b>	
<b>Sole Member, Buckeye Psychiatry, LLC</b>	

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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:

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Today's date:

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**Psychiatric History**

What problem brings you here?

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When did it start?

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Are the symptoms constant or intermittent?

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

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

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

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

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

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Do you have a history of self mutilation?

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Have you ever received ECT (shock treatments)?

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

Med

Response/Side Effects

1. 

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2. 

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3. 

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4. 

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5. 

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6. 

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7. 

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**Medical History**

What medical problems do you have?

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Who is your primary care doctor?

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

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Do you have any prescription drug allergies?

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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?

<u>Relative</u>	<u>Disease/Illness</u>
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

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

<u>Relative</u>	<u>Condition</u>
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

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

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**Background**

Where were you born?

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Who were you raised by?

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What is your parent's marital status?

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How many siblings do you have?

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What is your marital status?

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If you are not married are you dating?

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

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How many children do you have?

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Who do you turn to for emotional support?

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

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What is the highest educational level you completed?

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Where are you currently employed?

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

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Do you have a history of violent behavior?

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Do you have access to firearms?

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

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What hobbies or activities do you enjoy?

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Do you have any religious preferences?

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**Substance History**

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

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Drug	First used	Last used	Highest amnt used	Current amnt used

Other Notes or Information: