Ohio Psychiatry Specialists
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Independence, OH 44131
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INTAKE FORM

DEMOGRAPHIC INFORMATION

NAME: DOB: GENDER: RACE:

PHONE: MARITAL STATUS: AGE:

ADDRESS:

PHARMACY NAME: PHARMACY TOWN: PHONE:

MEDICAL HISTORY

ALLERGIES: NO ALLERGIES: (CIRCLE)

Medical conditions that you currently (or in the past) have received treatment for (including surgeries):

_____
_____
_____
_____

Current medications (include all medications for any condition):

Medication Name	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Past psychotropic medications that you have been prescribed:

_____ _____
_____ _____
_____ _____
_____ _____

Primary Care Provider and other treating Physicians or Therapists:

Name	Type of Provider	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Psychiatric Hospitalizations

Have you ever been Psychiatrically Hospitalized? YES NO

If yes, Location(s) and Date(s):

_____
_____
_____
_____

Substance Abuse

Are you currently, or have you in the past, abused nicotine?

_____

Are you currently or have you in the past used, abused, or been dependent on opiates (including pain medications), marijuana, cocaine, or other drugs of abuse?

_____
_____
_____

Do you drink alcohol? If so, type, amount, and frequency:

_____
_____

This form has been completed to the best of my knowledge and ability.

_____ _____

NAME **DATE**