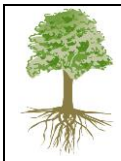

Indiana Professional Psychological Services
6825 Parkdale Place, Suite C
Indianapolis, Indiana 46254
(317) 981-5418 Office (317) 981-5429 Fax

Instructions: **Complete this Intake Form if you wish, print, and bring to your first appointment as part of your Protected Health Information.** ***Please Do Not Email. Thank you.***

Today's Date:

Your Name:			
Date of Birth:	Age:		
Gender:	☐ Male ☐ Female		
Partner Status:	☐ Married - Spouse name:	# times	# yrs current
	☐ Divorced	# times	# yrs current
	☐ Separated Length time	☐ Widowed	Length time
	☐ Never Married	☐ Cohabitating	Length time

BRIEFLY LIST **areas of concern. Don't worry; we will explore these in greater detail at your first appointment.**

1.

2.

3.

4.

5.

There is a specific topic I wish to discuss at my first appointment, not listed here: ☐ Yes ☐ No

---------- Previous Counseling or Treatment ----------

(1) Previous Counselor Name?	Date and # of Sessions?	Topic and/or Diagnosis?
(2) Previous Counselor Name?	Date and # of Sessions?	Topic and/or Diagnosis?
Intensive Outpatient: ☐ Yes ☐ No	Location?	
Inpatient? ☐ Yes ☐ No	Location?	
Drug/Alcohol Educ. ☐ Yes ☐ No	Location?	

---------- Current Stressors ----------

Y	N	Event	Comments / Details
☐	☐	Recent Marriage / Relationship	
☐	☐	Separation / Divorce / Break-up	
☐	☐	Serious Arguments / Violence	
☐	☐	Death / Loss Issues	
☐	☐	Children left home/returned home?	
☐	☐	Health Problems / pain issues	
☐	☐	Sexual dysfunction	
☐	☐	Abuse / recent or remote?	
☐	☐	Academic / Occupation problems	
☐	☐	Retirement / change of lifestyle	
☐	☐	Legal Problems	
☐	☐	Financial Pressures	
☐	☐	Other: Specify	
☐	☐	Other: Specify	

---------- Strengths / Supports / Assets ----------

☐ Family	☐ Spouse	☐ Support group	☐ Intelligence	☐ Financial
☐ Church	☐ Friends	☐ Emotional Insight	☐ Motivated	☐ Prev. Counseling
☐ Stability	☐ Hopeful	Other:		

Who currently lives in your household (relationships/first names):

---------- Education / Social / Employment / Legal History ----------

Education History	Highest Level of Education:			
	Degree(s):			
Are There Groups You Belong To?	☐ None			
	☐ Recreation**:**	Describe:		
	☐ Study:	Describe:		
	☐ Support:	Describe:		
How Do You Characterize Your Friendships?	☐ None	☐ Acquaintances	☐ Few Close	☐ Several Close
Hobbies & Spare Time Activities	Describe:			
Religious Preference	Current:		Family History:	
	☐ Active	☐ Moderately Active	☐ Inactive	
	Belief in Higher Power: ☐ Yes ☐ No			
	Name of Church:			
Employment	Current Company:		Years:	
	Job Title/Description:			
	Previous Employment:			
Legal History	☐ None If Yes, explain:			
Military History	☐ Yes ☐ No	Branch of Service:		
		Dates of Service:		
		Combat Involvement: ☐ Yes ☐ No		

---------- Nutritional Assessment ----------

Appetite: ☐ Good ☐ Fair ☐ Poor Duration:		
Weight Loss: ☐ Yes ☐ No	If yes, Amount:	Time Period:
Weight Gain: ☐ Yes ☐ No	If yes, Amount:	Time Period:
Worries About: ☐ Weight ☐ Body Shape ☐ Food Eaten?		
History of binge eating, restricting, or purging?	☐ Yes ☐ No Details:	
Do You Skip Meals?	☐ Yes ☐ No Details:	
Dietary Restrictions?	Specify:	

---------- Current and Past Medications ----------

Medication	Dose/Freq	Started	Stopped	Response	Prescribed For	Prescribed By
(Example):Name	100 mg qd	Month/yr	Month/yr	Good/fair/poor	depression	Doctor Name

qd = once a day bid = twice daily tid = three times qid = four times prn= as needed T - # of tabs

Medication Allergies: ☐ No ☐ Yes	Specify:

---------- Brief Medical Information ----------

Primary Care Physician:	Phone:
Additional Doctor & Specialty:	Phone:
Additional Doctor & Specialty:	Phone:
Additional Doctor & Specialty:	Phone:
Date of Last Physical Exam:	Findings:
Surgeries / Hospitalizations:	

---------- Treatment Goals ----------

What Would You Like To See Change As a Result Of Our Working Together?

1.

2.

3.

4.

Estimated # Of Sessions To Reach Your Goals? ☐ 1 to 5 ☐ 6 to 10 ☐ 11-20 ☐ ??

Signature: Person Completing This Form: _____ **Date** _____