



Indiana Professional Psychological Services

6408 Constitution Drive
 Fort Wayne, Indiana 46804
 (260) 469-0090 Office

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
	Never Married		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):
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----- **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

----- **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:
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----- 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 _____