

## Counseling Services General Intake Form

## **General Information**

Date:		Gender	: Male	☐ Fe	male	
Name:						_
First	Middle		Last			
Student ID # Birthda	ate (mm/dd,	/уууу)	A	ge		
Permanent Home Address	Lo	cal Address				
Permission to use as a contactYN	Pe	ermission to I	use as a cor	itact	- Y	_N
Home Phone	May we co	ontact you at	this numbe	r	_Y	_ N
	May we lea	ave a messag	e on this nu	umber	_Y	_ N
Cell/Local Phone	May we co	ontact you at	this numbe	r	_Y	_ N
	May we lea	ave a messag	e on this nu	umber	_Y	_ N
Email Address:		Permission t	o use as a c	ontact	_ Y	_N
Emergency Contact Person: Name		Relatio	nship:			
Phone Number	r					
Is your primary Language English Y N	If No, pr	imary Langua	age		_	
Ethnic Status: White/Caucasian		Bla	ack/African	American	I	
Asian American/Pacific Isla	ander	Hi	spanic/Latir	าด		
Native American/America	ın Indian	Int	ternational	Student/0	Other	
Marital Status: Single married	divorce	ed sep	parated _	other		
Are you a military veteran Y N	Active	(Branch	)	)		

Current Major:			Freshma	an _	Sophomore _	Junior	_ Senior
Current GPA	Cumul	ative GPA	Athlete:	_Y _	N		
Are you currently emp	loyed: _	YN	Hours/wee	k	If yes, Type of w	ork	
Do you have a religious	s/spiritu	al preference _	YN If	Yes:			
Medical History							
Current Medical Condi	tions:						
Have you previously be	een hosp	oitalized: Please	e explain				
Are you currently unde	er the ca	re of a physicia	n Y N				
Physician Name and nu	umber _				May we	contact?	Y N
Current Medications (i	nclude c	losage)					
Known Allergies							
Issues with: Hea	ring _	Visio	on	Spe	ech		
Major Presenting Issues							
	Mild	Moderate	Severe	I	Duration (days/we	eks/months)	
Depression				-			
Anxiety				-			
Thought Disturbance				_			
Relationship Problem				_			
Family Problems				_			
Alcohol Abuse				-			
Drug Abuse				_			
Health Problems				_			

Abuse			<del></del>
Mood disorders			·····
Other			<del></del>
Past history of therapy	or psychiatric care:		
May we contact Y _	N Contact Number:		
Do you have any or hav	e experienced any of the fo	llowing:	
Suicidal Thoughts	Homicidal Thought	ts	
Been a victim of:	Sexual abuse Phy	sical Abuse	Emotional Abuse
Been a perpetrator of:	Sexual Abuse	_ Physical Abuse	Emotional Abuse
Family History:			
Who raised you?			
Briefly describe your ch	ildhood:		
Is your family supportiv	e of treatment?		
Arry raining history of the	ental illness or suicide? Expl	dIII	
Substance Abuse Histo			
	•		
	Daily 1-6 days a	week 1-4 times a m	onth Occasionally Never
Marijuana		<del></del>	
Alcohol			
Opiates			
Cocaine			

Methamphetamines					
Heroin					
Benzodiazepines					
Other					
ssues with other addictions:					
Gambling Spending Sex/Porn	Other				
Referral Source:					
Self FriendFaculty/Advisor _	Student HealthCareer Services				
Student Success Center Accessibility ServicesStudent Support Services					
Family DeanRA/RD Othe	er:				
For Office Use Only:					
Purpose of Visit					
Individual Short Term Counseling	Crisis Emergency Counseling				
Couples/Marriage Counseling	Academic/Career Counseling				
Consultation/Coaching	Education				
Group	Class Project				
Sanction Request	Other				
Axis I Axis II Axis III Notes:					