Intake Questionnaire

Name: _____ Birthdate (mm/dd/yy): _____ ID: _____

Cell Phone: _____ Hometown (city, state): _____

Class Year: Fr So Jr Sr Grad Major:_____ GPA: _____

Who referred you to counseling? _____

Reason for visit/concerns: _____

_____

How long has it been occurring? _____

What have you tried to do to address it? _____

Mark Yes or No as appropriate	Yes	No
Have you had previous counseling?		
Have you been hospitalized for mental health reasons?		
Are you having suicidal thoughts?		
Have you ever had suicidal thoughts?		
Have you thought out how you would kill yourself?		
Have you ever attempted to kill yourself?		
Do you have access to firearms?		
Do you currently self-harm (cutting, burning, etc.)?		
Do you have thoughts or plans of hurting someone else?		
Are you currently experiencing anxiety, panic episodes, phobias, obsessions?		
Are you distressed by compulsive behaviors?		
Have you recently experienced any trauma? (Examples: abuse, rape, car accident)		
Are you currently experiencing overwhelming sadness, grief, or depression?		

Family Medical History

Type	Yes	No	Relationship
Alcohol/Substance Abuse			
Anxiety			
Depression/Bipolar			
Domestic Violence			
Eating Disorder			

Type	Yes	No	Relationship
Obesity			
OCD			
Schizophrenia			
Suicide Attempts			
Suicide Completion			
Other:			

List any:

Medical problems/surgeries: _____

All prescribed medications: _____

Over the counter medications and supplements used: _____

Allergies:_____

How do you rate your health? *Poor* *Unsatisfactory* *Good* *Very Good*

How often do you exercise?_____ What type? _____

Describe any difficulties with appetite, eating or weight?_____

On average, how many hours of sleep do you get per night? _____

Describe any sleep difficulties? _____

Mark Yes or No as appropriate	**Yes**	**No**
Do you drink alcohol more than once a week?		
Has anyone expressed concerns about your use of alcohol?		
Do you use marijuana regularly?		
Do you smoke cigarettes or vape?		
Other drug use?		
Any legal problems and/or campus violations?		

How much time do you spend on social media (per day)? _____

How much time to you spend playing video games or gambling?_____

Mark Yes or No as appropriate	**Yes**	**No**
Any developmental, learning, or physical disabilities?		
Academic problems or changes?		
Are you in a romantic relationship?		
Do you consider yourself spiritual or religious?		
Do you have any current concerns about your identity, sexuality, race, or cultural issues?		

Immediate family information:

Father's Name: _____ Age:_____ Occupation: _____

Mother's Name: _____ Age:_____ Occupation: _____

Siblings: _____ Age: _____ _____ Age: _____

Siblings: _____ Age: _____ _____ Age: _____

Who are your support person(s) by first name(s): _____

Is there anyone for whom you would like to sign a release? *Parents* *Physician* *Professor* *Counselor*

What are your strengths and coping skills? _____

What do you hope to accomplish in counseling?_____

Patient Signature: _____ Date:_____

Counselor Signature: _____ Date:_____