:::::::::: QVCC Supportive Counseling Intake Form::::::::::

Please complete this form clearly and thoroughly. The information on this form will be handled in a strictly confidential manner and will be used by your counselor to offer you the best help possible. Please print and bring this to your first appointment.

Section 1: General Information

Name:_____Student ID#:_____

Today's Date:_____Date of Birth:_____Age:_____

Gender: □ Female □ Male □ Transgender □ Other (identify) _____

Physical Address:_____
Mailing Address:_____
Home phone:_____ OK to phone? Yes □ No □ Ok to leave a message? Yes □ No □
Cell Phone:_____ OK to phone? Yes □ No □ Ok to leave a message? Yes □ No □

Ethnic/Race Origin: □ American/Alaska Native □ Asian □ Black or African American □ Hawaiian/Pacific Islander □ Hispanic/Latino □ Non-Hispanic/Latino □ White □ Other (identify) _____

Sexual Orientation: □ Heterosexual □ Lesbian □ Gay □ Bi-sexual □ Questioning □ Prefer not to answer

Relationship Status: □ Single □ Married □ Cohabitant □ Separated □ Divorced □ Widowed

□ In a relationship □ Prefer not to answer

Religious Affiliation:_____

May we acknowledge you on campus?: Yes □ No □ # years at QVCC:____

Major:_____Current Credit Load: _ Did you transfer from another campus/institution to this school? Yes □ No □

Are you currently employed? □ Yes □ No If yes, number of hours worked per week:_____

What kind of housing do you currently have?:

_____

With whom do you live:_____

Military Status:

□ Active □ Veteran □ Other_____

Section 1: General Information (continued)

1. Emergency Contact Name:_____

Relationship to you:_____

Physical Address:_____

Please list any on-going health problems:

_____

_____

Specify any medications you are currently taking:

_____

_____

Physician Name, Address and Phone Number

_____

_____

Have you previously had counseling? Yes □ No □

Are you currently receiving counseling or psychiatric services at another location? Yes □ No □

If you answered "yes", to the above three questions, where, when, how long, did it help and for what purpose?:

_____

_____

_____

_____

_____

In the past, have you ever been given a mental health diagnosis from a mental health professional? Yes □ No □

If yes, as you understand it, what is/was the diagnosis?

_____

Are you registered with the office for disability services on this campus, as having a documented and diagnosed disability? Yes □ No □

Section 2: Description of Presenting Issue(s): Symptom(s)—please check all that have occurred within the last 2 weeks.

□ Abuse (physical, sexual, verbal)

□ Alcohol/Substance Abuse

□ Aggressive Behavior

□ Angry Feelings

□ Anxiety/Worry

□ Blackouts/Memory Loss

□ Compulsive Behaviors

□ Concussions

□ Crying

□ Decreased need for sleep

□ Depressed Mood

□ Difficulty Concentrating

□ Difficulty falling asleep

□ Difficulty making friends

□ Difficulty staying asleep

□ Distrust

□ Dizzy or lightheaded

□ Eating Disorder

□ Experienced a traumatic event

□ Family emotional problems

□ Fatigue/Loss of energy

□ Feeling as if you'd be better off dead

□ Feeling manipulated or controlled

□ Feeling concerned about your sexuality or sexual behavior

□ Feeling that people are watching you and out to get you

□ Feelings of worthlessness

□ Fear of specific places/objects

□ Financial Concerns

□ Food insecurity

□ Grief/Loss

□ Health Problems

□ Hearing Voices

□ Housing Concerns

□ Impulsive Behaviors

□ Inability to control thoughts

□ Indecisive

□ Issues with food/weight

□ Jumpy

□ Lack of motivation

□ Lesbian, Gay, Bi-sexual, Transgender/Queer (LBGTQ) Concerns

□ Loneliness

□ Low Motivation

□ Medications

□ Muscle Tension

□ Nightmares

□ Numbness/lack of emotion

□ Obsessions

□ Odd behavior/thoughts

□ Outbursts of temper

□ Overeating

□ Pain

□ Problems with school

□ Recent appetite changes

□ Recent weight gain or loss

□ Relationship problems

□ Restlessness

□ Self-Esteem/Confidence

□ Shortness of breath

□ Sleeping too much or too little

□ Social withdrawal

□ Stressed/under pressure

□ Suicidal Thoughts

□ History of Suicidal Thoughts

□ Sweating

□ Traumatic Brain Injury

□ Trembling or shaking

□ Other:_____

_____

_____

In the past, what has been helpful to you, in dealing with these presenting issue(s)?:

_____

_____

_____

_____

Have any members of your family had problems with: □ Drugs □ Alcohol □ Depression □ Anxiety □ Major Illness

Do you drink alcohol more than once a week? Yes_____No _____

If yes, how often? _____

Is alcohol an area of concern for you? Yes_____No_____

If yes, explain:

_____

_____

How often do you engage in recreational drug use? Daily_____Weekly____Monthly_____Never_____

Is recreational drug use an area of concern for you? Yes_____No_____

If yes, explain:

_____

_____

Describe the problem(s) that led you to enter counseling:

_____

_____

What would you like to work on in counseling?

_____

_____

Is your academic success being impacted by any problems? If so, how:

_____

_____

_____

What kind of support system do you have? (Family, friends, groups, religious/spiritual support):

_____

_____

What are three things that you are grateful for?

_____

_____

Thank you for fully completing this form. Remember this form will not be a part of your academic record, it will be stored separately and safely by Supportive Counseling.