**:::::::::: 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.**