:::::::::: 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. Free printing available in Student Success Center and Library.

Section 1: General Information

Today's Date: _____

Name: _____Student ID#: _____

Preferred Name/ Pronouns:_____

Date of Birth: _____ Age: _____

Address: _____

Phone: _____ OK to call? Yes □ No □ Ok to leave a message? Yes □ No □

Email: _____ OK to email? Yes □ No □

Best Days/Times to schedule an appointment: _____

Relationship Status: □ Single □ Married □ Engaged □ In a relationship □ Separated □ Divorced □ Widowed □ Prefer not to answer

Do you have any children: □ yes □ no How Many/ Ages:_____

Who do you currently live with: _____

Section 2: Educational/ Occupational Information

Major/Program/Area of Study: _____Number of classes: _____
Circle last year of school completed 9 10 11 12 GED College Other # years at QVCC: _____
Occupation/Job Title:_____ □ Full Time □ Part Time

Military Service/Status (including branch of service and dates) _____

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

Section 3: Reasons for Seeking Counseling Services:

What concerns led you to seek out counseling services? _____
_____
_____
_____

Please rate the severity of your present concern(s): □ Mild □ Moderate □ Severe
When did this begin to be a problem for you? _____
Are you currently receiving counseling services: □ yes □ no
Have you received counseling services in the past? □ yes □ no

What do you hope to gain from counseling? _____
_____
_____
_____

Thank you for 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.

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(Optional) Section 4: 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**
- □ **Concerns regarding identity**
- □ **Concerns regarding sexuality or sexual behavior**
- □ **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 problems**
- □ **Fatigue/Loss of energy**
- □ **Feeling as if you'd be better off dead**
- □ **Feeling manipulated or controlled**
- □ **Feeling that people are watching you and out to get you**
- □ **Feelings of worthlessness**
- □ **Fear of specific places/objects**
- □ **Financial Concerns**
- □ **Food insecurity/ Hunger**
- □ **Grief/Loss**
- □ **Health Problems**
- □ **Hearing Voices**
- □ **Housing Concerns**
- □ **Impulsive Behaviors**
- □ **Inability to control thoughts**
- □ **Indecisive**
- □ **Issues with food/weight**
- □ **Jumpy**
- □ **Lack of motivation**
- □ **Loneliness**
- □ **Low Motivation**
- □ **Medication**
- □ **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:_____**

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