



Counseling Center | Intake Form

Date: _____

Name (Please Print Clearly): _____

G# _____

Date of Birth: _____ Age: _____

Male Female

Phone Number: _____ E-mail Address: _____

Hometown and State: _____ Ethnicity: _____

Year in School: _____ Major: _____

Do you reside on campus? Yes No

Are you a transfer student? Yes No

If yes, which college/university did you transfer from? _____ When? _____

Are you currently involved in any extracurricular activities (i.e. sports, job, clubs, student leadership, choir, etc.)?

CONTACT INFORMATION IN CASE OF AN EMERGENCY

Campus Residence Hall and Room # (or off-Campus address): _____

In case of an emergency, whom may we contact? _____

Relationship to you: _____ Phone: (_____) _____ - _____

1. Who referred you for counseling? _____
 - a. Can we contact that person and tell him/her that you came for an appointment? (Note that we will NOT disclose the content of your appointment; only that you attended.) Yes No
 - b. Are you being required to come to counseling? Yes No
If yes, can we contact that person and tell him/her the dates you attended counseling? Yes No
2. Have you been to Concordia University's Counseling Center before? Yes No
If yes, when? _____ Reasons: _____
3. Have you ever consulted with a mental health professional before? Yes No
If yes, when? _____ Reasons: _____
4. Have you ever had thoughts, made statements, or attempted to hurt or kill yourself? Yes No If yes, please describe: _____
5. Have you ever had thoughts, made statements, or attempted to hurt someone else? Yes No If yes, please describe: _____

6. Have you recently been physically hurt, or threatened by someone else? Yes No If yes, please describe: _____

7. Are you currently taking any medication? Yes No
If yes, please list the name/type, amount and purpose of each medication: _____
How often do you take these medications? _____
Who prescribes them? _____

8. Are you currently taking any herbal remedies or dietary supplements? Yes No
If yes, please list name/type, amount and purpose of each supplement: _____

9. Do you have any ongoing medical conditions? Yes No
If yes, please describe: _____

10. Have you ever been hospitalized? Yes No What for? _____

11. Do you have a regular primary care provider? Yes No
When was your last check-up? _____

12. Do you regularly engage in any type of exercise? Yes No
Please describe nature, frequency, intensity: _____

13. Please list your immediate family members (parents, step parents, siblings, children, etc.):

Name:	Relationship to you:	Age:	Deceased?	When?	Occupation:

14. Are your parents: Married Divorced Separated Never Married Widowed Other
If other, please explain: _____

15. Has anyone in your family ever been seen by a mental health professional? Yes No
If yes, please explain: _____

16. Please briefly describe your relationship with your parents and siblings: _____

17. Have you ever spoken with your family about your current concerns? Yes No

18. Please describe the quality of your relationship with friends (check all that apply):

I have a few supportive friends I feel content with my friends I wish I had more friends

19. Please describe your interpersonal style (check one):

I tend to be more introverted I tend to be more extroverted I have qualities of both

20. Whom do you consider to be your primary support? _____

21. Describe your spiritual framework and/or religious identity: _____

Would you like to discuss your spirituality/faith in counseling? Yes No

22. What are your greatest strengths? _____

23. What are your greatest weaknesses? _____

24. Please explain briefly what brought you for counseling at this time and what you are hoping to gain: _____

25. Are you currently struggling with, or do you have a history of struggling with, disordered eating behavior (binge eating, anorexia, bulimia, etc.)? Yes No

Please explain: _____

26. Have you been assaulted in the last calendar year? Yes No

If yes, please specify: Physical Sexual Other: _____

Where did this assault occur? _____

27. Please **CIRCLE** the number that best describes your current concerns.

Rate the **OVERALL** severity of your concern at this time:

None Mild Moderate Extreme
 0 1 2 3 4 5

To what degree are your concerns affecting your **academic functioning**?

None Mild Moderate Extreme
 0 1 2 3 4 5

To what degree are your concerns affecting your **ability to get along with others**?

None Mild Moderate Extreme
 0 1 2 3 4 5

28. How often do you consume drinks containing alcohol?

Never Monthly or less 2-4 times/month 2-3 times/week 4+ times/week

29. How many standard drinks of alcohol do you have on a **typical day** when you are drinking?

(One standard drink equals 12 oz. of beer, 5 oz. of wine, or 1.5 oz. of 80-proof spirits.)

1 or 2 3 or 4 5 or 6 7 to 9 10 or more

30. Please indicate which of the following have resulted from your use of alcohol/drugs **in the last year** (check all that apply):

- Injury to you
- Injury to someone else
- DUI/DWI
- Black outs
- Arguments or conflicts with friends/significant other
- College disciplinary action (Explain): _____
- Academic problems (Explain): _____
- Other legal problems (Explain): _____
- Other (Explain): _____
- None of these

31. Based on an **average month**, please check to indicate your frequency of use.

	Daily	Weekly	Monthly	Rarely	Never
Caffeine (coffee, soda, energy drinks)					
Marijuana (pot, hash, hash oil)					
Cocaine (crack, rock, freebase)					
Amphetamines (diet pills, speed, meth, crank)					
Nicotine					
Other psychoactive drugs					
Over-the-counter meds					
Other: _____					

32. Please check the box that corresponds to your **current** degree of distress for each of the following potential concerns.
If a problem does not apply to you, mark N/A (Not Applicable)

	N/A 0	Mild 1	2	Moderate 3	4	Extreme 5
Depressed mood						
Anxiety/Nervousness/Worry						
Mood Swings						
Aggression/Anger						
Thoughts of harming others						
Intention to act on thought of harming others						
Suicidal thoughts/behaviors						
Intention to act on thoughts of suicide						
Self harm behavior (cutting/scratching/burning etc)						
Being self-critical or feeling guilty						
Concerns about your physical appearance						
Family alcohol problems						
Dealing with a loss from death, separation, or illness						
Loneliness/Homesickness						
Problems with your living situation						
Problems in a romantic relationship						
Abusive relationship(s)						
Difficulty getting along with others						
Family conflict or other issues						
Concerns about your spirituality/religious beliefs						
Concerns about your sexual identity						
Adjusting to a new culture or other cross-cultural issues						
Experiencing prejudice or discrimination						
Difficulty with a disability						
Sexual harassment						
Unwanted sexual experience						
Being a victim of violence						
Alcohol/drug use						
Stress						
STD/HIV/AIDS						
Appetite/Eating						
Disordered eating (anorexia, bulimia, binge eating)						
Sleep disruption						
Excessive internet use or gaming						
Other addictions (gambling, pornography, shopping, etc.)						
Grades/Academic performance						
Concerns about major or career choice						
Motivation						
Organization						
Concentration						
Time management/Procrastination						
Financial Problems						
Adjustment to college						
Legal Problems						