CONFIDENTIAL COUNSELING INFORMATION

Name:_____ Student ID # _____ Birthdate: _____

Worner Box #:_____Best phone on which to reach you:_____

Student insurance? ❑ Yes ❑ No (check one) If no, name of your health insurance: _____

Consent for services/evaluation:

I voluntarily apply for and consent to diagnostic and treatment services provided by the qualified mental health professionals of Colorado College Counseling Center. I am aware that the mental health services are not based on an exact science and that the type(s) of treatment received will depend primarily on my needs and abilities. I understand that, as such, I cannot be given any guarantees about the results of treatment services. I understand that I may withdraw my consent at any time.

Client Signature_____ Date _____

Gender: _____ Age: _____ First Generation (College Student): ❑ Yes ❑ No

Race/Ethnicity (circle one): African American | Latinx | Caucasian | Asian | Native American | Native Hawaiian | Two or More

International Student: ❑ Yes ❑ No Country of Origin: _____

ACADEMIC INFORMATION

CLASS STATUS (circle one): First Year Sophomore Junior Senior Graduate

ACADEMIC MAJOR: _____ ADVISOR: _____

How does your concern affect your attendance at the College? "Due to this concern, I am considering…"

(circle one) No effect Withdrawing Not enrolling next block Transferring to another college

HEALTH INFORMATION

How would you describe your overall physical health in the last year? (circle number)

Poor 1 2 3 4 5 Good

Do you have a current health problem? ❑ Yes ❑ No (check one) If yes, please list including duration:

_ _____

Are you registered with disability services here on campus? ❑ Yes ❑ No (check one) If yes, please explain:

_ _____

MENTAL HEALTH

Please write the reason you are seeking counseling today: _ _____

_____

How would you rate your level of distress? (circle one) Low 1 2 3 4 5 High

Were you referred to counseling? ❑ Yes. If yes, circle one below. ❑ No. If no, go on to next question.

Faculty Dean Residential Life Staff Health Service Family Member Other_____

Have you sought psychotherapy or psychological counseling here or elsewhere? ❑ Yes ❑ No (check one)

If yes, where?_ _____ How long? _____

Have you ever had a problem with alcohol or drugs? ❑ Yes ❑ No (check one) If yes, when?_ _____

Do you drink now? ❑ Yes ❑ No (check one) If yes, how many each day?_____ each week? _____

Symptoms: Please check either "YES" or "NO" if you have noticed any of the following in the last six months. Please explain "Yes" responses:

- ❑ Yes ❑ No Trouble sleeping/nightmares_____
- ❑ Yes ❑ No Appetite/weight change_____
- ❑ Yes ❑ No Energy change (either fatigue or too active)_____
- ❑ Yes ❑ No Gastro-intestinal (digestion) problems_____
- ❑ Yes ❑ No Anxiety or panic attacks_____
- ❑ Yes ❑ No Depression_____
- ❑ Yes ❑ No Interpersonal problems_____
- ❑ Yes ❑ No Sexual problems_____
- ❑ Yes ❑ No Suicidal thoughts_____
- ❑ Yes ❑ No Homicidal thoughts_____

MEDICATIONS

Do you take medications now? ❑ Yes ❑ No (check one) If yes, which ones and how often?

_ _____

_ _____

_ _____

Have you taken medications for psychological problems in the past?_____

HOSPITALIZATIONS

Have you ever been hospitalized for emotional problems? ❑ Yes ❑ No (check one) If yes, when and where?

_ _____

_ _____

_ _____