COUNSELING SERVICES
CONFIDENTIAL INTAKE INFORMATION

I. IDENTIFYING INFORMATION

Last name	First	MI	Preferred name (if different)

Local address (street/number)	City	State	Zip
Permanent address (number & street)	City	State	Zip

☐ Local phone number	☐ Cell phone number	☐ Work phone number	☐ Email

☑ Indicate above how we can contact you and/or leave a message. We will not identify this department or state why we are calling.

Student Number	Age	Birth Date	☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married ☐ Living Together ☐ Separated ☐ Divorced ☐ Widowed

Class/year: ☐ Freshman ☐ Sophomore ☐ Junior ☐ Senior ☐ Graduate ☐ Other:	Major	☐ Full-time ☐ Part-time	Hours currently enrolled	GPA

Race: (Optional) ☐ Caucasian ☐ Asian American ☐ Native American ☐ African American ☐ Hispanic American ☐ Other:	Residence Type: ☐ Off Campus ☐ Residence Hall ☐ With Family ☐ Other:

Disability Type: (Optional) ☐ No disability ☐ Physical ☐ Learning ☐ Visual ☐ Behavioral ☐ Hearing ☐ Other:	Name of health insurance company:
Contacts In Case Of Emergency* Name: Relationship: Phone:	Other MD or therapist who is treating you: Name: Profession: Phone:

*NOTE: These persons will be contacted only with your permission, or in case of emergency, such as a threat of suicide or violence.

II. MEDICAL HISTORY

Do you have any medical problems? ☐ No ☐ Yes If yes, describe:

Are you currently taking prescribed, over-the-counter, or herbal medications? ☐ No ☐ Yes If yes, which ones?

Do you use alcohol/drugs now? ☐ No ☐ Yes If yes, what kinds?	How much daily? How much weekly?
Have you ever had previous psychological counseling? ☐ No ☐ Yes If yes, when? With Whom: For How Long:	Have you ever been hospitalized for a suicide attempt, drug or alcohol problem, or an emotional/behavioral problem? ☐ No ☐ Yes If yes, where? When? For How Long?

III. SERVICES SOUGHT

What type(s) of services are you seeking?	Which one of the following statements most accurately characterizes you?
☐ Individual counseling ☐ Couples counseling ☐ Counseling group ☐ LD/ADD Testing ☐ Alcohol/drug concern ☐ Other:	☐ As far as I'm concerned, I do not have any problems that I need to change. ☐ I am aware of some problems and am considering beginning to work on them. ☐ I am currently taking steps to overcome the problems that have been bothering me. ☐ I have already overcome some problems and want help now to avoid backsliding.

Please briefly describe why you are seeking services:

On a scale of one to ten, how distressed have you been during the last week? (circle one) 1 2 3 4 5 6 7 8 9 10 None Some Extremely	Are you experiencing thoughts of suicide or violence now or within the past two weeks? ☐ Yes ☐ No

As a result of your visit(s) to Counseling Services, what do you most want to achieve, resolve, change, or discover?

What is your present religious affiliation: __Catholic __Jewish __Protestant __None, but I believe in God __Atheist/Agnostic __Other _____

Are you open to the use of Scripture or Prayer as a part of your counseling experience? ☐ Yes ☐ No ☐ Uncertain

List any spiritual concerns or question that you may have:

How did you find out about Counseling Services? Who referred you to us? (Check all that apply.) ☐ Self ☐ Friend ☐ Family ☐ Health Services ☐ Judicial Sanction ☐ Student Success Center ☐ Undergraduate Studies ☐ Residence Life ☐ Faculty/staff member ☐ Other: ☐ Please notify this person that I came in (only the fact that you came in will be shared unless you specifically provide consent regarding additional information).	To what extent would you estimate that your concerns have an effect on your attendance at CSU? ☐ No Effect ☐ I am considering withdrawing ☐ I am considering not enrolling next semester ☐ I am considering transferring to another College

Please sign and date

Signature: Date:

CONTINUE TO NEXT PAGE