**Name: Age: Gender you identify as:**

**Phone Number: Is it ok to leave voicemail? Is it ok to send text message appointment reminders?**

**Email address:**

**Address :**

**Please list any medications for mental health you are currently taking:**

**Who is your current prescriber for mental health medications?**

**Religious Affiliation:**

**Ethnicity: Asian/Pacific Islander American Indian Hispanic African American Caucasian Other**

**Relationship Status: Single Married Divorced Separated Widowed Partnered**

**Referral Type: Self Friend Family School Court Other**

**Please describe the concerns you would like to discuss with a counselor:**

**How long have you had these concerns?**

**Please list the goals you wish to achieve in counseling. Consider the way you would like to feel, problems you wish to solve, and coping skills you would like to learn:**

**Please rate each, using the following scale:** Not at all Mildly Moderately Highly

How serious do you consider your present concern(s)? I-----------------------------------------------------------------------------------I

How motivated are you to resolve your concern(s)? I-----------------------------------------------------------------------------------I

How optimistic are you that this can be resolved? I-----------------------------------------------------------------------------------I

**Please answer EACH question:**

1. Have you previously been involved in counseling? Yes No
2. Have you ever been hospitalized for mental health reasons? Yes No
3. Do you currently use alcohol or non-prescribed drugs? Yes No
4. Is there a history of mental health problems in your family? Yes No
5. Have you ever been in legal trouble? Yes No
6. Have you ever been abused in any way? Yes No
7. Are you currently taking any prescription medications? Yes No
8. Are your concerns interfering with your work/school? Yes No
9. Are your concerns interfering with your ability to go to work/ school? Yes No
10. Have you ever attempted suicide? Yes No
11. Are you currently suicidal? Yes No

**Please check all of your personal strengths:**

reliable

organized

sensitive

resourceful

reserved

active

understanding

humorous

generous

patient

adaptable

determined

optimistic

likable

artistic

courageous

practical

mature

friendly

open-minded

motivated

trustworthy

intellectual

assertive

healthy

confident

calm

attractive

introspective

forgiving

loving

kind

loyal

supportive

outgoing

realistic

trusting

responsible

independent

honest

intelligent

sociable

**Please rate the concerns that are currently problematic for you, using the following scale:**

 Mild Moderate Serious Severe

1. Relationship difficulties: I-----------------------------------------------------------------------------------I

2. Family problems: I-----------------------------------------------------------------------------------I

3. Depression/moods: I-----------------------------------------------------------------------------------I

4. Suicidal thoughts or concerns: I-----------------------------------------------------------------------------------I

5. Anxiety: I-----------------------------------------------------------------------------------I

6. Stress symptoms: I-----------------------------------------------------------------------------------I

7. Physical health: I-----------------------------------------------------------------------------------I

8. Anger management: I-----------------------------------------------------------------------------------I

9. Academic difficulties: I-----------------------------------------------------------------------------------I

10. College adjustment: I-----------------------------------------------------------------------------------I

11. Cultural adjustment: I-----------------------------------------------------------------------------------I

12. Racial harassment: I-----------------------------------------------------------------------------------I

13. Self-esteem: I-----------------------------------------------------------------------------------I

14. Death or loss: I-----------------------------------------------------------------------------------I

15. Spiritual/religious concerns: I-----------------------------------------------------------------------------------I

16. Eating concerns or body image: I-----------------------------------------------------------------------------------I

17. Alcohol and/or chemical use: I-----------------------------------------------------------------------------------I

18. Self-inflicted harm: I-----------------------------------------------------------------------------------I

19. Sexual abuse or harassment: I-----------------------------------------------------------------------------------I

20. Sexual health: I-----------------------------------------------------------------------------------I

21. Sexual identity: I-----------------------------------------------------------------------------------I

22. Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I-----------------------------------------------------------------------------------I

**Please share any additional information you feel is important for your counselor to know:**