Avila Counseling Services Intake Form

The following information is needed to best help you and will remain confidential. Please print clearly.

Section1 - Identifying Information

Name____ Maiden Name__________________
First Middle Last

Local Address____

Age_____ Date of Birth______________ Gender ☐ M ☐ F Student ID#_______________

Please describe your race/ethnicity____

Major_________________________ GPA_______ Number of Hours Enrolled___________

Student Status ☐ First Year ☐ Sophomore ☐ Junior ☐ Senior ☐ MBA ☐ MA ☐MS ☐ ILCP

Academic Status ☐ Full Time ☐ Part-time Are you an international student? ☐ Yes ☐ No

Please describe your living situation____
(For example, live with parent(s), friend, roommate, significant other, self)

Employer_________________________________ Job Title__________________________

Contact Information

Best phone where you can be reached__________________ May we leave a message? ☐ Yes ☐ No

Note: Any phone message will not identify you as someone who is seeing a counselor. It will say the message is from Hodes Center.

E-mail Address_____________________________ May we send an email message? ☐ Yes ☐ No

Emergency Contact____
Name Phone Relationship to You

Section 2 - Referral Source

Who referred you to counseling?

☐Faculty_________________________________

☐Staff___________________________________

☐Coach__________________________________

☐Residence Hall Staff_____________________

☐Student Development Staff_______________

☐Academic Dean

☐Friend

☐Saw a Flyer

☐Avila Website

☐Email

☐Other__________________________________

May we contact the person who referred you only to confirm that you attended this first session?

☐ Yes ☐ No

If you checked "Yes," please sign here

____

Were you referred as part of a disciplinary sanction or Athletic Department Policy? ☐ Yes ☐ No

Section 3 - Treatment and Medical History

Are you currently receiving or seeking counseling from some person/agency other than a counselor at Avila?

☐ Yes ☐ No If yes, with whom?______________________________

Have you ever been treated by a psychiatrist, psychologist, clinical social worker or counselor? ☐ Yes ☐ No

Problem	Therapist	When	Helpful (Yes or No)

Have you seen a counselor at Avila prior to this semester? ☐ Yes ☐ No If yes, when?____________

Name and location of Physician______________________________

Date of last physical exam______________________________

Current medical conditions ______________________________

Any known allergies? ☐ Yes ☐ No If yes, please describe______________________________

Do you have any disabilities? ☐ Yes ☐ No If yes, please describe______________________________

Have you ever had a head injury or loss of conscious for more than 2 minutes? ☐ Yes ☐ No

Please list any significant illnesses, hospitalizations and/or injuries.

Dates	Problem	Treatment

Please list all medications you are now taking or have taken in the past three months, including birth control pills, vitamins, herbs, and supplements.

Medication	Dose	Purpose	Prescribing Physician	Helpful (Yes or No)

Section 4: Alcohol and Drug Use History

ALCOHOL
Do you use? ☐ Yes ☐ No Age at first use:____________________ Date of last use:______________
Usual amount:____

TOBACCO
Do you use? ☐ Yes ☐ No Age at first use:____________________ Date of last use:______________
Usual amount:____

CANNIBUS
Do you use? ☐ Yes ☐ No Age at first use:____________________ Date of last use:______________
Usual amount:____

STIMULANTS (Cocaine, Crack, Crank, Amphetamines, “uppers”, speed)
Do you use? ☐ Yes ☐ No Age at first use:____________________ Date of last use:______________
Usual amount:____

HALLUCINOGENS (LSD, Shrooms, Ecstasy)
Do you use? ☐ Yes ☐ No Age at first use:____________________ Date of last use:______________
Usual amount:____

PRESCRIPTION(S)
Do you use? ☐ Yes ☐ No Age at first use:____________________ Date of last use:______________
Usual amount:____

OTHER (please list)______________________
Do you use? ☐ Yes ☐ No Age at first use:____________________ Date of last use:______________
Usual amount:____

For what reason(s) do you use alcohol and/or other drugs (check all that apply)?
☐ To manage stress ☐ To relax ☐ To change mood ☐ For sleep ☐ Social ☐ Other___________

Have you ever gotten into trouble for things you have done while using alcohol or other drugs? ☐ Yes ☐ No

Have you had any accidents related to the use of alcohol or other drugs? ☐ Yes ☐ No

Section 5: Description of Presenting Problem

Please state why you decided to come for counseling. ____
____
____
____

How long has this been a problem for you?____

Please describe any incidents or problems that may have triggered and/or been associated with this problem (e.g., problem with academic program, loss of job, relationship ending).

____
____

In the past, what has been helpful to you in dealing with this type of problem?

____

____

Areas of Concern (check all that apply)

☐ Academic	☐ Grief/Loss	☐ Self-Esteem
☐ Alcohol/Drugs	☐ Health Concerns	☐ Sexual Concerns
☐ Anxiety	☐ Homesickness	☐ Sexual Orientation
☐ Body Image	☐ Identity	☐ Sleep Problems
☐ Career/Work	☐ Insecurity	☐ Social
☐ Decision-Making	☐ Past/Current Trauma	☐ Social / Family Relations
☐ Depression	☐ Personal Concerns	☐ Stress
☐ Eating Related	☐ Personal Goals	☐ Suicidal / Homicidal Thoughts
☐ Family of Origin	☐ Relationship	☐ Worries / Fears
☐ Financial Problems	☐ Roommate Problems	Other:

Symptoms Related to Concerns (check all that apply)

☐ Agitation	☐ Easily Distracted	☐ Pain
☐ Aggressive Behavior	☐ Fatigue/Loss of Energy	☐ Paranoid Thoughts
☐ Anger	☐ Fears/Phobias	☐ Rapid Heart Rate
☐ Avoidance	☐ Feelings of Hopelessness	☐ Recent Weight Gain / Loss
☐ Compulsive Behaviors	☐ Feelings of Worthlessness	☐ Restlessness
☐ Confusion	☐ Jumpy	☐ Shortness of Breath
☐ Constant Worrying	☐ Low Motivation	☐ Too Much/Little or Disrupted Sleep
☐ Crying	☐ Muscle Tension	☐ Social Withdrawal
☐ Decreased Need for Sleep	☐ Nightmares	☐ Stomach Problems
☐ Depressed Mood	☐ Obsessions	☐ Sweating
☐ Difficulty Concentrating	☐ Odd Behavior/Thoughts	☐ Taking Drugs
☐ Distrust	☐ Outbursts of Temper	☐ Trembling or Shaking
☐ Drinking Alcohol	☐ Overeating	☐ Other:

How much distress has this problem caused you in the past week, including today?

1 2 3 4 5 6 7 8 9 10

None A little bit Moderate Quite a bit Severe

How much is this problem interfering with your usual routine?

1 2 3 4 5 6 7 8 9 10

None A little bit Moderate Quite a bit Severe

How much is this problem interfering with your ability to perform academically?

1 2 3 4 5 6 7 8 9 10

None A little bit Moderate Quite a bit Severe

How much is this problem affecting you socially?

1 2 3 4 5 6 7 8 9 10

None A little bit Moderate Quite a bit Severe

How likely is it that you may need to leave Avila because of your problem?

1 2 3 4 5 6 7 8 9 10

None A Little Maybe Possible Likely

What do you want to be different as a result of coming to counseling? ___________________________

____

____

____

Section 6 - Family of Origin and Current Family Status

Relationship	Name	Age	Occupation	Deceased (Y/N)
Mother				
Father				
Stepmother (If applicable)				
Stepfather (If applicable)				
Siblings				
Spouse/Partner				

Do you have children? ☐ Yes ☐ No If yes, please complete the table below.

Name	Gender	Age	Do they live with you?

Are your parents divorced? ☐ Yes ☐ No

Were you raised by someone other than parents/stepparents? ☐ Yes ☐ No

Name Relationship Age Occupation Deceased (Y/N) / Date

____

____

Have any members of your family had problems with:

☐ Drugs ☐ Alcohol ☐ Depression ☐ Anxiety ☐ Other Mental Illness ☐ Diabetes ☐ Epilepsy

If yes, please describe:____

____

____

If applicable, describe your relationship with your current significant other (partner/spouse/boyfriend/girlfriend):

☐ Major Problems ☐ Minor problems ☐ Satisfactory ☐ Very satisfactory

How long have you been in this relationship?_______________________________________