

Instructions:

1. Print the form.
2. Complete it, and bring it with you when you make your appointment.
3. Please do not email or fax the form since these are both non-secure methods of transmission. Therefore, we cannot guarantee your confidentiality.
4. If you have any questions, please call us at 395-2207.

INTAKE QUESTIONNAIRE

STUDENT HEALTH AND COUNSELING CENTER

*The College at Brockport
State University of New York*

*Division of Enrollment Management and
Student Affairs*

INFORMED CONSENT

The Counseling Center and the Health Center together make up what is referred to as Student Health Services. We realize that you may have concerns about providing highly personal information. **All records at Student Health Services are confidential.** Information may be released to appropriate individuals or agencies **only upon your written request.**

CONFIDENTIALITY will be maintained except under the following conditions and with the following limits:

- 1) **If needed, we will seek supervision and consultation from professional colleagues within Student Health Services to aid us in our work with you. These colleagues also must treat your information as confidential, within the same legal limits.**
- 2) If we believe you pose a life-threatening risk to yourself or others, we may need to notify responsible individuals for your protection and/or the protection of others.
- 3) If you are under the age of 18 and a victim of child abuse, we are required by law to file a report with Child Protective Services.
- 4) If records are subpoenaed directly by a court, we are required by law to release records and perhaps be called to testify at those proceedings.
- 5) If you reveal to us that you are abusing your, or any, minor child we are required by law to file a report with Child Protective Services.
- 6) If you are referred to our psychiatric consultant, a copy of our evaluation may be placed in your Health Center file, and we may consult with Health Center Staff.

If circumstances necessitate the release of information outside Student Health Services as outlined above, you will be notified as soon as reasonably possible. In all other situations, information may be released to appropriate individuals or agencies only upon your written request. If you have any questions regarding the above conditions, please discuss them with your intake counselor.

I have read and understand the statements regarding Informed Consent

Signature

Date

Please provide the following information

Please complete this questionnaire so that we may obtain a more comprehensive picture of your current concerns and background. Please answer the questions as honestly and accurately as you possibly can. Your answers will help us determine the best way we can serve you.

DATE ____/____/____

BANNER ID # ____-____-____

NAME: _____
Last First MI

Local Address: _____
Street City Zip Code

Permanent Address: _____
Street

Local Phone number: _____ / _____
Home (Leave message? Yes__ No__) Cell (Leave message? Yes__ No__)

Birth date: ____/____/____ Age ____ Ethnicity _____

Class: FR SO JR SR Grad Non-matric Status: FT/PT Major: _____
GPA: _____

Who suggested you come to the Counseling Center? _____

Have you ever had counseling before? If so, when/where? _____

****What brings you to the Counseling Center today?**

Below is a list of issues that sometimes cause concern. Please indicate those that currently apply to you:

Academic/Career Concerns

- | | |
|--|--|
| <input type="checkbox"/> Grades | <input type="checkbox"/> Uncertainty about major/goals |
| <input type="checkbox"/> Learning disability _____ | <input type="checkbox"/> Performance/test anxiety |
| <input type="checkbox"/> Study skills | <input type="checkbox"/> Difficulty concentrating/focusing on work |
| <input type="checkbox"/> ADD/ADHD | |

Interpersonal Concerns

- | | |
|---|---|
| <input type="checkbox"/> Relationship with friends/roommate | <input type="checkbox"/> Relationship with parents/family |
| <input type="checkbox"/> Relationship with significant other | <input type="checkbox"/> Difficulty making friends |
| <input type="checkbox"/> Adjusting to being at college/away from family | <input type="checkbox"/> Difficulty being assertive |
| <input type="checkbox"/> Social anxiety concerns | |

Depression

- | | |
|---|---|
| <input type="checkbox"/> Suicidal thoughts/gestures | <input type="checkbox"/> Irritability/anger issues |
| <input type="checkbox"/> Overeating | <input type="checkbox"/> Sleep problems |
| <input type="checkbox"/> Under eating | <input type="checkbox"/> Sad mood |
| <input type="checkbox"/> Feeling hopeless | <input type="checkbox"/> Crying for "no reason" |
| <input type="checkbox"/> Feeling worthless/guilty | <input type="checkbox"/> Lack of energy/motivation |
| <input type="checkbox"/> Decreased interest in activities | <input type="checkbox"/> Fatigue/feeling tired all the time |
| <input type="checkbox"/> Extreme mood swings | |

Anxiety

- | | |
|--|--|
| <input type="checkbox"/> Fearful for no apparent reason | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Shakiness |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Hot flashes |
| <input type="checkbox"/> Fear of losing control or "going crazy" | <input type="checkbox"/> Obsessive thoughts/images/worries |
| <input type="checkbox"/> Excessive worry | <input type="checkbox"/> Repetitive behaviors or mental acts |

Trauma:

- History of sexual abuse
- History of physical abuse
- Date rape
- Victim of violence

- History of emotional/verbal abuse
- History of violence in relationships
- Unwanted sexual contact
- Other trauma: _____

Eating Concerns:

- Binge eating
- Restricting food intake
- Pre-occupation with food/dieting

- Purging after eating
- Body image
- Excessive exercising (more than 4 times a week)

Legal:

- Campus Judicial/Student Conduct referral
- Court or other legal mandate

Miscellaneous:

- Ethnic/racial concerns
- Financial problems
- STD concerns
- Pregnancy
- Difficulty controlling anger/impulses

- Sexual identity/orientation/gender concerns
- Sexual concerns
- Medical problem/concerns
- Mental illness in family
- Grief/loss issues

Medical History:

Are you taking any prescribed medications? _____ If so, please specify:

Who is your primary health care provider? _____ Do you utilize the Health Center? _____

Do you have any medical problems or concerns? _____ If so, please specify:

Please indicate if you have any of the following concerns and immediately advise your counselor:

- **Current thoughts of suicide** Yes ___ No ___
- **Previous attempts at suicide** Yes ___ Date of attempt _____ No ___
- **Prior psychiatric hospitalizations** Yes ___ Date of hospitalization _____ No ___
- **Current self-injurious behavior (e.g. cutting self)** Yes ___ No ___
- **Current thoughts of harming someone else** Yes ___ No ___
- **Current hallucinations/hearing voices** Yes ___ No ___

Alcohol/Drug

- Concerned about own use
- Concerned about another's use
- Alcoholism in my family

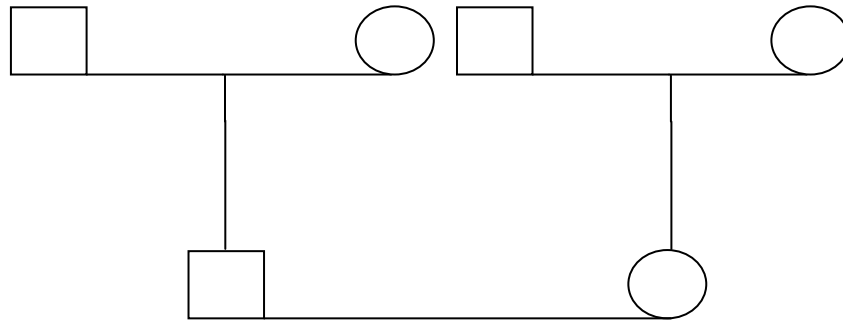
Alcohol/Drug Assessment:

Drug/Last Use	Age of First Use	How often are you currently using?				Date of Last Use
		Never	Daily	Weekly	Monthly	
Alcohol	_____	Never	Daily	Weekly	Monthly	_____
Marijuana	_____	Never	Daily	Weekly	Monthly	_____
Cocaine	_____	Never	Daily	Weekly	Monthly	_____
PCP	_____	Never	Daily	Weekly	Monthly	_____
Ecstasy	_____	Never	Daily	Weekly	Monthly	_____
Other _____	_____	Never	Daily	Weekly	Monthly	_____

Family Information: Please indicate information about your immediate family

Name/Relationship	Age	Occupation/School	Medical/Mental Health/ Substance Abuse History
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Genogram (counselor will create and review with you)



Please take a moment to tell us any other concerns you may have or issues you would like to discuss with your counselor. Thank you.
