

# Southeastern University Counseling Center

## Intake Form

1000 Longfellow Blvd. ~ Lakeland, FL 33801 ~ (863) 667-5205

*(Please complete this form before your first appointment. All information will be held confidential in accordance with State and Federal Law. Please print legibly.)*

**First Name** \_\_\_\_\_ **Last Name** \_\_\_\_\_ **Student ID#** \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Race: \_\_\_\_\_ Male \_\_\_ Female \_\_\_  
Your Email: \_\_\_\_\_ @seuniversity.edu *or* other: \_\_\_\_\_  
On campus students: Dormitory \_\_\_\_\_ Room #: \_\_\_\_\_ R.D. \_\_\_\_\_  
Home address: \_\_\_\_\_  
Off campus students: local address \_\_\_\_\_  
Contact number (\_\_\_\_\_) \_\_\_\_\_ Other number \_\_\_\_\_  
May we contact you at both phone numbers? Yes \_\_\_ No \_\_\_ If yes, what are the best times to call? \_\_\_\_\_

**Emergency Contact:** (name/relationship/phone) \_\_\_\_\_  
Who referred you to counseling? Self \_\_\_ Family/Friend \_\_\_ JRB \_\_\_ Staff/Faculty \_\_\_  
May we contact your referral source to thank them and let them know you came? Yes \_\_\_ No \_\_\_  
If yes, what is their name and email address? \_\_\_\_\_  
Name Email Address

### **PRESENTING PROBLEM:**

Why are you seeking counseling (present problem)? \_\_\_\_\_  
Approx. when did this problem begin? \_\_\_\_\_ How intense is it on a scale from mild to severe?  
(Circle a number from 1-5)      1                      2                      3                      4                      5  
   Mild                                      Moderate                                      Severe  
At what times is the problem *less* severe, or absent? \_\_\_\_\_

Are you currently, or have you recently been, having thoughts of suicide? Yes \_\_\_ No \_\_\_  
Have you made any attempts on your life? Yes \_\_\_ No \_\_\_ If yes, please describe below:

\_\_\_\_\_  
Month/Year                      Method of Attempt

### **Goals:**

What would you like to accomplish in counseling? \_\_\_\_\_

How committed are you to work toward personal growth and change at this time?  
Very uncommitted \_\_\_ Uncommitted \_\_\_ Neutral \_\_\_ Committed \_\_\_ Very committed \_\_\_

### **Previous Treatment:**

Have you received counseling or medication for this *or other* issues (including support groups)?  
Yes \_\_\_ No \_\_\_ If yes, please list: Counselor/Doctor name, address, telephone number & reason:

Reason: \_\_\_\_\_ Approximate dates: \_\_\_\_\_  
Have you ever been hospitalized for psychiatric reasons? Yes \_\_\_ No \_\_\_\_\_. If yes, please list:  
Hospital/Treatment Center, City, State      |      Reason      |      Approximate Dates

### **Substance Use – Do you:**

... use caffeine/energy drinks?    Daily \_\_\_    Frequently \_\_\_    Sometimes \_\_\_    Rarely \_\_\_    Never \_\_\_  
... smoke cigarettes?                      Daily \_\_\_    Frequently \_\_\_    Sometimes \_\_\_    Rarely \_\_\_    Never \_\_\_  
... drink beer or wine?                      Daily \_\_\_    Frequently \_\_\_    Sometimes \_\_\_    Rarely \_\_\_    Never \_\_\_  
... drink hard liquor?                      Daily \_\_\_    Frequently \_\_\_    Sometimes \_\_\_    Rarely \_\_\_    Never \_\_\_  
... use drugs?                                      Daily \_\_\_    Frequently \_\_\_    Sometimes \_\_\_    Rarely \_\_\_    Never \_\_\_

(Please list any current or past substance use) \_\_\_\_\_

**Symptom Checklist:**

Please mark any symptoms that you have experienced in the past (P) or current (C):

- |   |   |
|---|---|
| <input type="checkbox"/> Depression                   | <input type="checkbox"/> Anger Management Problems      |
| <input type="checkbox"/> Low Energy                   | <input type="checkbox"/> Panic Attacks OR Anxiety       |
| <input type="checkbox"/> Poor concentration           | <input type="checkbox"/> Job stress /Career issues      |
| <input type="checkbox"/> Low self esteem              | <input type="checkbox"/> Obsessive/Disturbing thoughts  |
| <input type="checkbox"/> Feelings of hopelessness     | <input type="checkbox"/> Compulsive behaviors           |
| <input type="checkbox"/> Feelings of worthlessness    | <input type="checkbox"/> Unresolved grief reaction      |
| <input type="checkbox"/> Excessive guilt              | <input type="checkbox"/> Divorce/separation             |
| <input type="checkbox"/> Sleep disturbance            | <input type="checkbox"/> Appetite disturbance           |
| <input type="checkbox"/> Excessive worrying           | <input type="checkbox"/> Eating disorder                |
| <input type="checkbox"/> Thoughts of harming yourself | <input type="checkbox"/> Sexual problems                |
| <input type="checkbox"/> Suicide Attempt              | <input type="checkbox"/> Homosexual thoughts/behaviors  |
| <input type="checkbox"/> Thoughts of harming others   | <input type="checkbox"/> Use of pornography             |
| <input type="checkbox"/> Social isolation             | <input type="checkbox"/> Adult abuse                    |
| <input type="checkbox"/> Communication difficulties   | <input type="checkbox"/> Traumatic experience           |
| <input type="checkbox"/> Family conflict              | <input type="checkbox"/> Childhood abuse/neglect        |
| <input type="checkbox"/> Marital problems             | <input type="checkbox"/> Excessive use of alcohol/drugs |
| <input type="checkbox"/> Legal problems               | <input type="checkbox"/> Spiritual Concerns             |
| <input type="checkbox"/> Unwanted sexual experiences  | <input type="checkbox"/> Relationship problems          |

Please explain any items you marked above (use the back if needed): \_\_\_\_\_

**Medical/Physical Health**

Please list any current medical problems/diagnoses, whether or not you are receiving treatment:

Medical diagnoses/condition: \_\_\_\_\_ Medication/Treatment \_\_\_\_\_

Please list **all major** surgeries, illnesses, head injuries, accidents, or hospitalizations **AND** dates:

Date and reason for last doctor's visit \_\_\_\_\_

Who is your primary care physician (name/address)? \_\_\_\_\_

Do you have any allergies or adverse reactions to medications? Yes \_\_\_ (List: \_\_\_\_\_) No \_\_\_

Problems with eating or weight control? Yes \_\_\_ No \_\_\_ Explain \_\_\_\_\_

Please list all current medications and the following: Physician \_\_\_\_\_

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Side Effects: \_\_\_\_\_ Results: Good \_\_\_ Fair \_\_\_ Poor \_\_\_

*Please use the back of this form to list multiple medications.*

Are you sexually active? Currently: Yes \_\_\_ No \_\_\_ In the Past: Yes \_\_\_ No \_\_\_

**Females only:** Are you pregnant? Yes \_\_\_ No \_\_\_ Regular Menstruation? Yes \_\_\_ No \_\_\_

Number of pregnancies: \_\_\_\_\_ Miscarriages: \_\_\_\_\_ Abortions: \_\_\_\_\_

**Family History**

Marital status: Single \_\_\_ Married \_\_\_ Divorced \_\_\_ Widowed \_\_\_

Spouse's Name: \_\_\_\_\_ Spouse's occupation: \_\_\_\_\_

Please list your children, names & ages: Boys: \_\_\_\_\_ Girls: \_\_\_\_\_

Do your children reside with you? \_\_\_ If no, with whom do they reside and why? \_\_\_\_\_

Father's name \_\_\_\_\_ Mother's name \_\_\_\_\_

Are your parents married? Yes \_\_\_ No \_\_\_ If yes, for how many years \_\_\_\_\_

If no, are they divorced \_\_\_ deceased \_\_\_ Remarried? \_\_\_ Step-parents? \_\_\_\_\_

Names and ages of siblings: \_\_\_\_\_

Family history of alcohol/drug abuse? \_\_\_\_\_ mental illness? \_\_\_\_\_ physical/sexual abuse? \_\_\_\_\_

If yes, which family member(s)? \_\_\_\_\_

What was the spiritual climate of your family growing up? \_\_\_\_\_

Would you say your family was *very close* \_\_\_ *close* \_\_\_ *neutral* \_\_\_ *distant* \_\_\_ *very distant* \_\_\_

**Social/Legal History**

Are you involved in any social clubs or small groups (list)? \_\_\_\_\_  
List hobbies, recreational activities: \_\_\_\_\_  
Do you have any legal issues pending? Yes \_\_\_ No \_\_\_ Please List: \_\_\_\_\_  
Have you ever been arrested, or convicted of a crime? Yes \_\_\_ No \_\_\_ If yes, please list date, crime committed, and current status of your case: \_\_\_\_\_

**Educational History**

Are you are Freshman \_\_\_ Soph. \_\_\_ Jr \_\_\_ Sr \_\_\_ Expected Graduation Date: \_\_\_\_\_  
At SEU, is this your 1<sup>st</sup> Year \_\_\_ 2<sup>nd</sup> Year \_\_\_ 3<sup>rd</sup> Year \_\_\_ 4<sup>th</sup> Year \_\_\_ 5<sup>th</sup> Yr or higher \_\_\_  
Are you a transfer student? \_\_\_\_\_ If yes, where did you transfer from? \_\_\_\_\_  
How many credit hrs are you carrying this semester? \_\_\_ How many do you usually carry? \_\_\_  
What is your Major \_\_\_\_\_ Minor \_\_\_\_\_  
How satisfied are you with your current choice of major/minor?  
Very Dissatisfied \_\_\_ Dissatisfied \_\_\_ Neutral \_\_\_ Satisfied \_\_\_ Very Satisfied \_\_\_  
What is your current estimated GPA? \_\_\_\_\_ How satisfied are you with your grades?  
Very Dissatisfied \_\_\_ Dissatisfied \_\_\_ Neutral \_\_\_ Satisfied \_\_\_ Very Satisfied \_\_\_  
Have you considered leaving school or dropping classes due to the issues that brought you to counseling?  
Yes \_\_\_ No \_\_\_

**Occupational History**

Are you currently employed? Yes \_\_\_ No \_\_\_ If yes where do you work? \_\_\_\_\_  
How many hours do you work per week? \_\_\_\_\_ How long have you been employed? \_\_\_\_\_  
How satisfied are you with your current occupation/career?  
Very Dissatisfied \_\_\_ Dissatisfied \_\_\_ Neutral \_\_\_ Satisfied \_\_\_ Very Satisfied \_\_\_  
Please list past occupations: \_\_\_\_\_

**Spiritual History**

What is your religious affiliation/denomination? \_\_\_\_\_  
Do you consider yourself a Christian? \_\_\_\_\_ If yes, how long? \_\_\_\_\_  
Do you have a home church locally? Yes \_\_\_ No \_\_\_ If yes, church name: \_\_\_\_\_  
How often do you attend church (not including chapel)? \_\_\_\_\_  
How often do you read your Bible? Daily \_\_\_ Frequently \_\_\_ Sometimes \_\_\_ Rarely \_\_\_ Never \_\_\_  
How often do you pray/meditate? Daily \_\_\_ Frequently \_\_\_ Sometimes \_\_\_ Rarely \_\_\_ Never \_\_\_  
How satisfied are you with your spiritual life?  
Very Dissatisfied \_\_\_ Dissatisfied \_\_\_ Neutral \_\_\_ Satisfied \_\_\_ Very Satisfied \_\_\_  
If you are not satisfied, what would help improve your satisfaction with your spiritual life?  
\_\_\_\_\_

Your confidentiality is protected. If you are willing to consent to information being **anonymously** collected in future research projects for the purpose of improving university counseling practices and helping future clients, please initial here: \_\_\_\_\_  
client initials All names and identifiers will be eliminated.

Please add any additional information/comments that you think would be helpful on the back.

\_\_\_\_\_  
**Client Signature** **Date**

\_\_\_\_\_  
**Counselor Signature** **Date**