

(cc use only)	Phone Intake <input type="checkbox"/>	In Person <input type="checkbox"/>	Initials: _____	Date: _____	Time: _____
---------------	---------------------------------------	------------------------------------	-----------------	-------------	-------------

**TESC Counseling Center Initial Contact Data**

*Please print this form, fill it out and deliver, fax, or mail to the Counseling Center.*

Name: \_\_\_\_\_ Gender: \_\_\_\_\_ Referred by: \_\_\_\_\_ Age: \_\_\_\_\_

Phone #1: Please check one: <input type="checkbox"/> home <input type="checkbox"/> cell <input type="checkbox"/> work	OK to call and identify <input type="checkbox"/> Yes <input type="checkbox"/> No	OK to leave message <input type="checkbox"/> Yes <input type="checkbox"/> No
Phone #2: Please check one: <input type="checkbox"/> home <input type="checkbox"/> cell <input type="checkbox"/> work	OK to call and identify <input type="checkbox"/> Yes <input type="checkbox"/> No	OK to leave message <input type="checkbox"/> Yes <input type="checkbox"/> No
Email if no phone :	OK to call and identify <input type="checkbox"/> Yes <input type="checkbox"/> No	OK to leave message <input type="checkbox"/> Yes <input type="checkbox"/> No

Address:	City:	State:	Zip:	ID#
Ethnicity:	Year(s) at TESC:	Year in College:	Date of Birth:	
Class or Program:	# Credits this quarter:	Do you live on campus? <input type="checkbox"/> Yes <input type="checkbox"/> No		
WA state resident: <input type="checkbox"/> yes <input type="checkbox"/> no	Are you a veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No	Access Services? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Key Services? <input type="checkbox"/> Yes <input type="checkbox"/> No	First Peoples? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Insurance Provider:	Mental Health Benefits: <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure			

***We use the following information to determine how to best meet your needs. Please be specific.***

What do you want to see a counselor about? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

How long has this been a problem? (e.g., days, weeks, months, etc.) \_\_\_\_\_

How much does this problem impact your current academic progress? (Circle One)

- |            |              |            |             |           |
|------------|--------------|------------|-------------|-----------|
| 1          | 2            | 3          | 4           | 5         |
| Not At All | A little bit | Moderately | Quite a bit | Extremely |

In the last two weeks, have you been afraid you might hurt yourself or someone else? \_\_\_\_\_

Has a friend or family member ever committed suicide?  Yes  No

If yes, please describe the person's relationship to you: \_\_\_\_\_

(Continued on Back)

How can the Counseling Center be most helpful to you / What would you like to change about your situation?  
 (e.g., goals for counseling) \_\_\_\_\_

*Groups can be extremely effective in coping with and managing problems, please indicate groups or workshops you would be interested in participating in and would like to be called about if or when they become available:*

<input type="checkbox"/> Assertiveness Group	<input type="checkbox"/> Men's Group
<input type="checkbox"/> Anger Management Group	<input type="checkbox"/> Managing Stress
<input type="checkbox"/> Avoiding Procrastination	<input type="checkbox"/> Making Relationships Work – Finding Love
<input type="checkbox"/> Coming Out Group	<input type="checkbox"/> Returning Student Transition Group
<input type="checkbox"/> Couples Therapy Group	<input type="checkbox"/> Relapse Prevention for Substance Abuse
<input type="checkbox"/> College Related Coping Skills	<input type="checkbox"/> Recognizing Boundaries
<input type="checkbox"/> Communication Skills Group	<input type="checkbox"/> Self-Esteem Group
<input type="checkbox"/> Eliminating Obsessions & Compulsions	<input type="checkbox"/> Social Anxiety & Social Phobia Group
<input type="checkbox"/> Eating Disorders Group	<input type="checkbox"/> Students of Color - Therapy Group
<input type="checkbox"/> Graduation Anxiety Group	<input type="checkbox"/> Students with Disabilities Therapy Group
<input type="checkbox"/> Grief & Loss Group	<input type="checkbox"/> Surviving Recent Trauma Group
<input type="checkbox"/> Gender Identity Group	<input type="checkbox"/> Surviving Childhood Trauma Group
<input type="checkbox"/> GLBT Couples Group	<input type="checkbox"/> Sexual Abuse & Rape Survivors Group
<input type="checkbox"/> Group Therapy Group	<input type="checkbox"/> Women's Group
<input type="checkbox"/> Managing Depression Group	<input type="checkbox"/> Others (Please List)
<input type="checkbox"/> Managing Emotions Group	

*Please indicate specific times you are available for appointments:*

<input type="checkbox"/> Monday	<input type="checkbox"/> 9am	<input type="checkbox"/> 10am	<input type="checkbox"/> 11am	<input type="checkbox"/> 1pm	<input type="checkbox"/> 2pm	<input type="checkbox"/> 3pm	<input type="checkbox"/> 4pm	<input type="checkbox"/> 5pm
<input type="checkbox"/> Tuesday	<input type="checkbox"/> 9am	<input type="checkbox"/> 10am	<input type="checkbox"/> 11am	<input type="checkbox"/> 1pm	<input type="checkbox"/> 2pm	<input type="checkbox"/> 3pm	<input type="checkbox"/> 4pm	<input type="checkbox"/> 5pm
<input type="checkbox"/> Wednesday	<input type="checkbox"/> 9am	<input type="checkbox"/> 10am	<input type="checkbox"/> 11am	<input type="checkbox"/> 1pm	<input type="checkbox"/> 2pm	<input type="checkbox"/> 3pm	<input type="checkbox"/> 4pm	<input type="checkbox"/> 5pm
<input type="checkbox"/> Thursday	<input type="checkbox"/> 9am	<input type="checkbox"/> 10am	<input type="checkbox"/> 11am	<input type="checkbox"/> 1pm	<input type="checkbox"/> 2pm	<input type="checkbox"/> 3pm	<input type="checkbox"/> 4pm	<input type="checkbox"/> 5pm
<input type="checkbox"/> Friday	<input type="checkbox"/> 9am	<input type="checkbox"/> 10am	<input type="checkbox"/> 11am	<input type="checkbox"/> 1pm	<input type="checkbox"/> 2pm	<input type="checkbox"/> 3pm	N/A	N/A