

TESC Counseling Center

The following information is needed to best help you. Please clearly print your response to each question. This will help save time in your first session. If you are unable to complete some parts, then leave them blank and you will have a chance to complete them with your counselor. Case records are strictly confidential.

SECTION I: IDENTIFYING INFORMATION

Today's Date: _____

Name _____ Student ID# _____ Date of Birth _____

Address _____ City _____ Zip _____ Home Phone _____

Work Phone _____ E-mail (optional) _____ Year(s) at TESC _____ Year in School _____ Age _____

Gender: F ___ M ___ Other _____ Program/Faculty _____

Emergency contact _____ Relationship _____ Phone _____

Who do you live with?

Name	Age	Relationship to you	Supportive? Y / N

SECTION II: DESCRIPTION OF PRESENTING PROBLEM

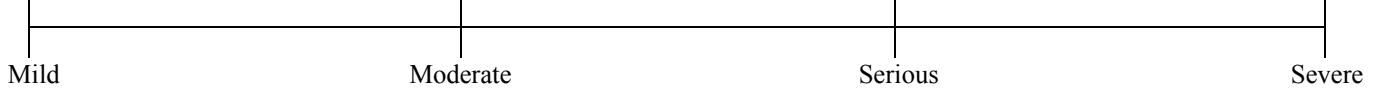
Please state why you decided to come to the Counseling Center:

Please tell us what you want to work on or change in counseling:

How long has this been a significant problem for you? *Please be specific (i.e., not "all my life")*.

Have you ever been given a mental health diagnosis in the past from a mental health professional? Yes ___ No ___
If yes, as you understand it, what is/was that diagnosis? _____

How would you estimate the severity of the problem at this time? (Place "X" on the line below)



What symptoms contributed to you coming in today? (Please check all that apply)

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> overeating | <input type="checkbox"/> restless | <input type="checkbox"/> rapid heart rate | <input type="checkbox"/> compulsive behaviors |
| <input type="checkbox"/> taking drugs | <input type="checkbox"/> depressed mood | <input type="checkbox"/> sweating | <input type="checkbox"/> impulsive behaviors |
| <input type="checkbox"/> odd behavior/thoughts | <input type="checkbox"/> crying | <input type="checkbox"/> trembling or shaking | <input type="checkbox"/> fears/phobias |
| <input type="checkbox"/> recent weight gain | <input type="checkbox"/> difficulty concentrating | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> anxiety |
| <input type="checkbox"/> recent weight loss | <input type="checkbox"/> low motivation | <input type="checkbox"/> muscle tension | <input type="checkbox"/> vomiting |
| <input type="checkbox"/> recent appetite changes | <input type="checkbox"/> aggressive behavior | <input type="checkbox"/> outbursts of temper | <input type="checkbox"/> distrust |
| <input type="checkbox"/> social withdrawal | <input type="checkbox"/> feelings of worthlessness | <input type="checkbox"/> nightmares | <input type="checkbox"/> jumpy |
| <input type="checkbox"/> family emotional problems | <input type="checkbox"/> stomach problems | <input type="checkbox"/> easily distracted | <input type="checkbox"/> dizzy or lightheaded |
| <input type="checkbox"/> chest pain | <input type="checkbox"/> sleeping too much | <input type="checkbox"/> decreased need for sleep | <input type="checkbox"/> fatigue/loss of energy |
| <input type="checkbox"/> difficulty falling asleep | <input type="checkbox"/> problems with school | <input type="checkbox"/> housing problems | <input type="checkbox"/> obsessions |
| <input type="checkbox"/> difficulty staying asleep | <input type="checkbox"/> pain | <input type="checkbox"/> drinking alcohol | <input type="checkbox"/> relationship problems |
| <input type="checkbox"/> experienced a traumatic event | <input type="checkbox"/> financial problems | <input type="checkbox"/> can't turn my mind off | <input type="checkbox"/> other: _____ |

If applicable, please describe any incidents or problems that may have contributed to this problem (e.g., problem with academic program, relationship ending, past trauma, etc.):

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

SECTION III: MEDICAL HISTORY

Name and location of Physician _____ Date of your last physical exam: _____

SECTION III: MEDICAL HISTORY (continued)

Please list any significant past or current **health, medical, or psychiatric issues** (including anything resulting in hospitalizations).

<u>Dates</u>	<u>Problem & Treatment</u>	<u>Were you hospitalized (Y/N)</u>

Have you ever experienced: (Please mark all that apply)

Emotional abuse _____ Physical abuse _____ Sexual abuse _____ Sexual assault _____

Have you **ever had treatment by**, or are you **currently seeing**, a psychiatrist, psychologist, therapist, or counselor? Yes ___ No ___

<u>Problem</u>	<u>Where</u>	<u>Therapist</u>	<u>When?</u>	<u>Helpful? (Y/N)</u>

SECTION IV: MEDICATIONS AND SUBSTANCES USED If applicable, please list all medications you are now taking or have taken in the past three months, **including birth control pills, vitamins, herbs and supplements.**

<u>Medication</u>	<u>Dosage</u>	<u>Person prescribing</u>	<u>How long have you been taking this?</u>	<u>Helpful (Y/N)</u>

If applicable, amount of **caffeinated** beverages per day: coffee _____ soda _____ espresso _____ tea _____

If applicable, number of cigarettes smoked per day: _____ If applicable, how often do you use marijuana per week? _____

Consider a typical week during the **past month**. Please fill in a number for each day of the week indicating the typical number of drinks you usually consume on that day and the typical number of hours you usually drink on that day.

1 Drink = 12 oz. beer / 10 oz. microbrew / 8 oz. malt liquor
 4 oz. of wine
 1 oz. of hard alcohol (regular shot glass)

	Su	M	T	W	T	F	Sa
Number of drinks							
Number of hours							

Think of the occasion that you drank the most in the **past month**. How much did you drink? ___ How many hours did you drink? ___

If applicable, other substances used _____

SECTION IV: (continued)

Do you use alcohol or drugs to (check all that apply): Manage stress?__ To relax?__ To change mood?__ For sleep?__

How often do you gamble? (please mark one response)

- Never Once a Year 2 to 3 Times a Year Every Other Month Once a Month 2 to 3 Times a Month Weekly
 More Than Once a Week Every Other Day Every Day

SECTION V: FAMILY OF ORIGIN INFORMATION

	Age	Name	Occupation	Deceased (Y/N)
Parent/Guardian	_____	_____	_____	_____
Parent/Guardian	_____	_____	_____	_____
If applicable:				
Stepparent	_____	_____	_____	_____
Stepparent	_____	_____	_____	_____
Siblings	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
If applicable:			Living with you? (Y/N/Part time)	
Children	_____	_____	_____	_____
	_____	_____	_____	_____

Are your parents divorced? Yes _____ No _____

Have any members of your family had problems with:

drugs ___ alcohol ___ depression ___ anxiety ___ other mental illness ___ diabetes ___ epilepsy ___

Problem	Who	Current Y / N	Past Y / N

Among your friends and family, whom do you count on for support? _____

Are you: Single ___ Dating ___ Married / Partnered ___ Divorced / Unpartnered ___ Widowed / a surviving partner ___

If applicable, describe your relationship with your current partner (place an X on the line below).

Major Problems	Minor problems	Satisfactory	Very satisfactory
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How long have you been in the relationship? _____

Is there anything else we need to know to assist you? Please ask for an extra sheet of paper if needed.