



SECTION I: IDENTIFYING INFORMATION

Name: _____ Today's Date: _____

Address: _____ City, State, Zip: _____

Student ID#: _____ Date of Birth: ____/____/____ Age: _____

What do you prefer to be called? _____

Home phone: (____) _____ May we leave a message? Y N

Cell phone: (____) _____ May we leave a message? Y N

SCC email: _____ May we email you? Y N

Ethnic Background: African American Asian White Hispanic Native American
International Multiracial Other: _____

Sexual Orientation: Heterosexual Lesbian Gay Bisexual Questioning
Other: _____ Prefer not to answer

Marital Status: Single Married Separated Divorced Widowed Partnered

How were you referred to Personal Counseling Services?

Self Friend Professor/Advisor/Staff Other: _____

Current/Prior Military Service: Y N **Pending Court/Legal Issues:** Y N

How many credit hours are you taking this semester? _____

Program of study: _____

Are you currently employed? Y N Avg. # of hours worked weekly: _____

SECTION II: CURRENT CONCERNS

Please give a brief statement of what is bringing you to counseling today:



Please check the following items that reflect your top three concerns:

- Academic problems
- Anxiety
- Adjustment to college/life changes
- Social problems (i.e. shy, lack of social contact)
- Grief/ loss
- Suicidal thoughts/plan attempt
- Stress
- Depression
- Conflict in relationships
- Substance use (i.e. alcohol and other drugs)
- Auditory/visual hallucinations
- Homicidal thoughts/plan/attempt

Please circle any of the following symptoms/problems you may have recently experienced:

- weight loss/gain
- fatigue
- panic attacks
- anger outbursts
- concentration
- self-esteem
- mood shifts
- withdrawal

Please rate how your current concerns affect the following:

Concerns	Severely	Moderately	Slightly	Not at all
Ability to remain at SCC	4	3	2	1
Academic performance	4	3	2	1
Social relationships	4	3	2	1
Emotional well-being	4	3	2	1

Mark Yes or No as appropriate	Y	N
Have you had previous counseling?		
Have you been hospitalized for mental health reasons?		
Are you having suicidal thoughts?		
Have you ever had suicidal thoughts?		
Have you thought out how you would kill yourself?		
Have you ever attempted to kill yourself?		
Do you have access to firearms?		
Do you currently self-harm (cutting, burning, etc.)?		
Do you have thoughts or plans of hurting someone else?		
Are you currently experiencing anxiety, panic episodes, phobias, obsessions?		
Are you distressed by compulsive behaviors?		
Have you recently experienced any trauma? (Examples: abuse, rape, car accident)		
Are you currently experiencing overwhelming sadness, grief, or depression?		



SECTION III: MEDICAL HISTORY

Have you had any serious illness, physical problems or injuries? Y N

If yes, what? _____

Are you currently taking any medications? Y N

If yes, what? _____

SECTION IV: EMERGENCY CONTACT

Emergency Contact (parent or close relative or friend): _____

Relationship: _____

Emergency Contact Phone Number: () _____

Signed: _____ Date: _____

(Student)

I also give SCC Personal Counseling permission to provide counseling services for my minor child.

Parents or Legal Guardian if Client Is a Minor, Adult Lacking Legal Competency, or Personal Representative* Date

*If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (Power of Attorney, Healthcare Surrogate, etc.).

Signed: _____ Date: _____

(Counselor)

CCAPS ID
NUMBER: _____