PERSONAL COUNSELING INTAKE FORM

Name: ______________________________ Date: ______________________________

G#: ____________ Years in School (at PCC): _____ Major/Program: ______________________

Age: ____________ Gender: ____________________ Ethnicity: ____________________________

Are you registered in classes at PCC this term? ___ Yes ___ No

What are the reason(s) you are seeking counseling [Please check all that apply]?

- ☐ Academic / Educational Concerns
- ☐ Addictions (gambling, substance use, food, etc.)
- ☐ ADHD / ADD
- ☐ Adjustment to New Situations
- ☐ Alcohol or Drug Use
- ☐ Anger Management
- ☐ Anxiety, Fears, Nervousness
- ☐ Athletic Performance
- ☐ Career / Job Related
- ☐ Compulsive Behavior
- ☐ Concern with Other's Well Being
- ☐ Cutting or Self-Injury
- ☐ Depression, Sadness
- ☐ Disability Concerns
- ☐ Discrimination
- ☐ Eating Concerns / Body Image
- ☐ Episodes of Manic Behavior
- ☐ Faculty / Advisor Concerns
- ☐ Family Problems
- ☐ Feeling Doomed or Helpless
- ☐ Financial Difficulties
- ☐ Gender Identity Concerns
- ☐ Graduation Concerns
- ☐ Harassment
- ☐ Impulse Control
- ☐ Internet Use / Computer Games
- ☐ Intimate Relationship Concerns
- ☐ Learning Problems
- ☐ Legal Problems
- ☐ Loneliness
- ☐ Loss, Grief, or Death
- ☐ Marital/Partnership Concerns
- ☐ Medical or Health Related
- ☐ Mood Swings
- ☐ Multicultural Issues
- ☐ Obsessive Thoughts
- ☐ Panic Attacks
- ☐ Paranoia
- ☐ Phobias
- ☐ Physical Abuse or Assault
- ☐ Procrastination
- ☐ Re-Entry to College Concerns
- ☐ Self-Esteem
- ☐ Sense of Self / Identity
- ☐ Sexual Abuse or Assault
- ☐ Sexual Orientation Concerns
- ☐ Sexual Performance Concerns
- ☐ Sleep Difficulties
- ☐ Social Relationships/Interpersonal Issues
- ☐ Spiritual or Religious Struggles
- ☐ Stress or Tension
- ☐ Thinking about Suicide
- ☐ Thoughts Racing
- ☐ Trouble Concentrating
- ☐ Trouble Deciding/Getting Things Done
- ☐ Other: ______________________________

OVER ➡

PERSONAL COUNSELING INTAKE FORM

Are you a first generation college student (first in your family to attend college)?

- ☐ Yes
- ☐ No

Partnership Status:

- ☐ Single/Not in a relationship
- ☐ Dating
- ☐ Married/Life partner
- ☐ Separated/Divorced
- ☐ Widowed
- ☐ Other : ________________________

Length of relationship: _________________ Number of dependents: ________________

Are you employed?

- ☐ Yes
  *How many hours per week?*____
- ☐ No

Do you have health insurance?

- ☐ Yes
- ☐ No

Are you currently under the care of a mental health professional (e.g., counselor, psychologist, psychiatrist, etc.)?

- ☐ Yes
  *What is your diagnosis?*____
- ☐ No

Have you received counseling in the past?

- ☐ Yes
- ☐ No

Are you currently taking any medications for a psychological condition?

- ☐ Yes
  *Name of medication(s)?*____
- ☐ No

Are you working with a PCC Disability Services Counselor?

- ☐ Yes
  *Name of counselor:*____
- ☐ No

Do you have any significant medical conditions?

- ☐ Yes
  *Please describe:*____
- ☐ No

What would you like to accomplish in counseling?

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Thank you for taking the time to complete this form.