COLORADO COLLEGE

COUNSELING CENTER INTAKE FORM

DEMOGRAPHIC INFORMATION

Name:_____ Birthdate: _____ Age: _____

Phone Number:_____ Preferred Method of Contact: ❑ Phone ❑ Email

Gender: _____ Preferred Pronouns: _____ Sexual Orientation: _____

Race/Ethnicity: ❑ Black/African American ❑ Hispanic or Latino ❑ American Indian or Alaska Native ❑ White

❑ Asian ❑ Middle Eastern/North African ❑ Native Hawaiian or Other Pacific Islander ❑ Other:_____

First Generation (College Student)? ❑ Yes ❑ No

International Student? ❑ Yes ❑ No Country of Origin: _____

Student Insurance? ❑ Yes ❑ No If no, name of your health insurance: _____

Referral Source (If being referred): _____

Have you previously participated in Counseling/Therapy services? ❑ Yes ❑ No If yes, when? _____

ACADEMIC INFORMATION

Student ID #: _____ RA? ❑ Yes ❑ No Class Status: ❑ Freshman ❑ Sophomore ❑ Junior ❑ Senior ❑ Grad

Academic Major: _____ Advisor: _____

How does your concern affect your attendance at the College? "Due to this concern, I am considering…"

(select one): ❑ No effect ❑ Withdrawing ❑ Not enrolling next block ❑ Transferring to another College

FINANCIAL NEED FEE'S ASSESSMENT

Counseling Center fee's are structured to support every student regardless of income. The first **eight** Counseling Sessions are free to every student, after eight sessions the fee's will be charged to your student account or student health insurance plan. Medication Management reviews are charged immediately to either your student account or student health insurance plan. We do not bill private insurance directly, but we can provide a superbill for you to submit to your insurance for reimbursement. No student will be denied services at the Counseling Center due to financial restraints. Counseling Center scholarships are available if needed and will be determined by filling out this information.

In the last 12 months, have you needed to see a medical provider (doctor, dentist, mental health, optometrist, specialist), but could not because of how much it cost? ❑ Yes ❑ No

How would you rate your personal/family's financial situation? Fair ❑1 ❑ 2 ❑ 3 ❑ 4 ❑5 Good

What services are you requesting for fees to be waived? ❑ Counseling ($40 per session)

❑ Medication Management ($200-100 per session)

❑ Both ❑ Neither

WORK/SOCIAL INFORMATION

Living Situation (select one): ❑ On campus ❑ Off campus ❑ Other: _____

Are you currently employed? ❑ Yes ❑ No If yes, ❑ Part-Time ❑ Full-Time Where? _____

Do you participate in any of the following: ❑ Clubs ❑ Sports ❑Volunteering ❑Other: _____

Social Supports (ex: friends, family, romantic partners): _____

Do you practice any religion or spirituality? ❑ Yes ❑ No If yes, please list here: _____

FAMILY HISTORY

Where is your family located? _____

Who all is in your family? _____

Has anyone in your family been diagnosed or treated for mental health? ❑ Yes ❑ No If yes, please list here: _____

_____

MEDICAL HISTORY

How would you describe your overall physical health in the last year? (select number): Poor ❑1 ❑ 2 ❑ 3 ❑ 4 ❑5 Good

Have you ever been diagnosed with any mental health conditions? _____

Have you been diagnosed with any chronic health conditions? ❑ Yes ❑ No If yes, please list including duration:

_____

Do you receive any accommodations with from the accessibility office? ❑ Yes ❑ No If yes, please explain:

Do you currently take medications? ❑ Yes ❑ No If yes, which ones and how often?

Have you taken medications for mental health conditions in the past?_____

SUBSTANCE USE HISTORY

Have you ever had a problem with alcohol or drugs or been told you need to reduce your use? ❑ Yes ❑ No If yes,

When? _____ What substance/alcohol? _____

Do you currently use alcohol? ❑ Yes ❑ No If yes, how many beverages per day?____ How many per week?____

Do you currently use any of the following substances (select all that apply)?

❑Nicotine ❑Marijuana ❑Mushrooms ❑Cocaine ❑Molly ❑Opiates ❑Other: _____ How often? _____

MENTAL HEALTH INFORMATION

Please write the reason you are seeking counseling: _____

_____

How would you rate your level of distress? (select number) Low ❑1 ❑ 2 ❑ 3 ❑ 4 ❑5 High

Symptoms: Please select all symptoms you have noticed in the last six months.

❑ Disordered eating concerns	❑ Struggling with memory	❑ Intrusive thoughts
❑ Appetite/weight change	❑ Anxiety or panic attacks	❑ History of trauma
❑ Gastrointestinal problems	❑ Depression	❑ Interpersonal problems
❑ Energy Problems	❑ Self-harm	❑ Sexual problem
❑ Difficulties paying attention	❑ Suicidal thoughts	❑ Sleep disturbance/nightmares
❑ Fatigue	❑ Homicidal thoughts	

Explain:

HOSPITALIZATIONS

Have you had any prior suicide attempts? ❑ Yes ❑ No

Have you ever been hospitalized for any mental health conditions? ❑ Yes ❑ No If yes, when and where?

_____