

**PEACE COLLEGE COUNSELING CENTER
INTAKE FORM**

Name: _____ **Student ID#:** _____
(Last) (First) (Middle Initial)

Birth Date: ____ / ____ / ____ **Age:** ____ **Gender:** Female Other (specify _____)

Marital Status: Never Married Partnered Married Separated Divorced Widowed

Ethnicity: African/American Chicano/Mexican-American/Puerto Rican Chinese/Chinese American
 East Indian/Pakistani Filipino Japanese/Japanese American Korean/Korean-American
 Latino/Latino American/Hispanic Middle Eastern Native American/Alaskan Native
 Polynesian/Micronesian Vietnamese White/Caucasian Other (specify _____)

Local Address: _____
(Street and Number) (City) (State) (Zip)

Home Phone: (____) _____ - _____ **May we leave a msg?** Yes No

Cell Phone: (____) _____ - _____ **May we leave a msg?** Yes No

E-mail: _____ **May we email you?** Yes No

*Please be aware that email might not be confidential.

Emergency Contact Name: _____ **Relationship:** _____

Address: _____ **Phone:** _____

Status: Fr So Jr Sr Other _____ **Are you a Transfer Student?** Yes No

Residence: On-campus Off-campus Parent's/Relative's Home

Referred by: Self Professor/ Advisor Friend Dean Family Member Student Health
Other _____

Are you an international student? Yes No **Are you a student with disabilities?** Yes No

Insurance coverage: Other (please specify) _____

Are you currently receiving psychiatric services, counseling or psychotherapy elsewhere? Yes No

Have you had previous psychological counseling? No Yes, off campus
 Yes, at Peace

If yes, previous counselor's name? _____

LIFE FUNCTIONING INVENTORY

The information you provide will help in the planning of your counseling.

Name: _____

Date: _____

ACADEMIC BACKGROUND

1. Major: _____

2. Did you transfer from a community college? Yes No

3. Estimated high school GPA _____ Est. community college GPA _____ Est. Peace GPA _____

4. Average Peace hours per semester _____ Hours this semester _____

CULTURAL BACKGROUND

1. What is your **ethnic identity**? _____

2. How much do you identify with your **ethnic heritage**? (Circle one):

Not at all

A little

Somewhat

Moderately

Strongly

3. **Religious preference**: _____

Are you currently active in your religion? Yes Somewhat No

4. Does your family **speak a language** other than English at home? (Circle one):

Not at all

Very little

Sometimes

Frequently

Always

If "Sometimes" to "Always", what language is spoken? _____

5. Were you and both your biological parents **born in the USA**? Yes No Unsure

If no, who was foreign-born, where and what was the approximate age of immigration to the USA? (e.g. myself, Korea, 12; father Korea, 40; etc.) International students check here

EMPLOYMENT

1. Are you receiving financial aid? Yes No

2. Do you work on or off campus? Yes No If yes, # hours a week _____

Place of Employment _____

PROBLEM ANALYSIS

1. PROBLEM DESCRIPTION: Briefly **describe the problem** you most wish help with right now:

2. PROBLEM INTENSITY: How would you **rate the intensity** of the problem or concern that brought you in?
(Circle the appropriate number):

1 2 3 4 5 6
Not Intense Moderately Intense Extremely Intense

3. PROBLEM DURATION: Approximately **how long** have you had the current problem? _____

4. COPING ATTEMPTS: In what ways have you attempted to cope with this problem?

FAMILY BACKGROUND

1. Please list the **members** of your current family, including ages and occupations (e.g. father, 42, Lawyer; stepmother, 40, teacher; brother 16, student; etc.)

2. Please check any past, present, or impending special problems in your family:

- | | |
|---|--|
| <input type="checkbox"/> deaths | <input type="checkbox"/> physical/sexual abuse |
| <input type="checkbox"/> divorce | <input type="checkbox"/> financial crisis/unemployment |
| <input type="checkbox"/> frequent relocations | <input type="checkbox"/> legal problems |
| <input type="checkbox"/> debilitating injuries/disabilities | <input type="checkbox"/> attempted/completed suicide |
| <input type="checkbox"/> alcohol/drug abuse | <input type="checkbox"/> eating disorders |
| <input type="checkbox"/> serious illness | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> psychiatric disorder | |

Please specify family member(s), which special problem, and approximate year of occurrence (e.g. mother-serious illness, 1998 etc.)

3. Have you personally experienced significant **family abuse**?

- none unsure emotional physical sexual

4. Have you personally experienced **legal problems**? Yes No

5. Did you experience **learning problems** in elementary or high school? (Circle one):

- None Little Some Substantial Lots, constant struggle

6. In general, how **happy or adjusted** were you growing up? (Circle one):

- Poor Unsatisfactory About average Substantial Completely

7. How much is your immediate family a source of **emotional support** for you? (Circle one):

- None Little Somewhat Substantial Very Strong

8. How much **conflict in values** do you currently experience with your parents? (Circle one):

- Very little or none Some Moderate Strong Extreme

9. Who in your family do you currently **feel closest** to? _____

Most **distant** from? _____ In most **conflict** with? _____

HEALTH AND SOCIAL ISSUES

1. How is your **physical health** at present? Poor Unsatisfactory Satisfactory Good Very good

2. Please list any **persistent physical symptoms** or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):

3. Are you presently taking any **prescribed medication**? Yes No

please indicate _____

If no, have you previously been prescribed **psychiatric** medication? Yes No

When? _____ What? _____

4. Are you having any problems with your **sleep habits**? Yes No

(If yes, check where applicable): Sleeping too little Sleeping too much Poor quality sleep
 Disturbing dreams Other

5. How many times per week do you **exercise**? _____ For about how long each time? _____

6. Are you having any difficulty with **appetite or eating habits**? Yes No

(If yes, check where applicable): Eating less Eating more Binging Restricting
 Significant weight change (last 2 months)

7. Do you regularly use **alcohol**? Yes No
 In a typical month, how often do you have 4 or more drinks in a 24 hour period? _____
 Do you consider your alcohol consumption a problem? Yes No Unsure
8. How often do you engage **recreational drug use**? Daily Weekly Monthly Rarely Never
 Do you consider this drug use a problem? Yes No Unsure
9. Do you have any problems or worries about **sexual functioning**? Yes No
 (If yes, check where applicable): Lack of desire Performance Problem Sexual Impulsiveness
 Difficulties maintaining arousal Worried about sexually transmitted disease Other _____
10. Have you ever experienced **sexual assault, unwanted sex or uncomfortable touching**?
 Frequently A few times Once Never Unsure
11. Have you had **suicidal thoughts** recently? Frequently Sometimes Rarely Never
 Have you had them in the past? Frequently Sometimes Rarely Never
12. Have you ever intentionally **inflicted any harm upon yourself**? Yes No Unsure
13. In the past, how would you rate the quality of your **peer relationships**?
 Very Poor Unsatisfactory About Average Good Excellent
14. Approximately how many **significant intimate relationships** (e.g. lasting 6 months or more) have you been involved in? _____ Are you in one now? Yes No I think so
15. Besides family members, approximately how many people can you really count on right now for **friendship or emotional support**? _____

Thank you for filling out this intake form. We look forward to meeting you soon. Please call the Counseling Center at 508-2505 if you have any questions or concerns before your scheduled appointment time.