



Belmont Abbey COLLEGE

Intake Form

Date: _____

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. Case records are strictly confidential.

Name: _____ Student ID#: _____
(Last) (First) (MI)

Birth date: ____/____/____ Age: ____ Gender: Female Male Athlete? Team _____

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

Home Address: _____ Phone: _____

Class Status: FR SO JR SR Major: _____ Transfer student? Yes No

Who suggested you contact us? _____ Mandated? Yes No

Emergency Contact Name _____ Relationship: _____ Phone _____

What other campus resources are you currently using or have you used in the past? Career services, Academic Resource Center, Campus Ministry, Athletics, Health Services, Disability Services

Briefly describe the reason you are seeking counseling right now:

In what ways have you attempted to cope with this problem?

List any prescribed medication you are currently taking, the reason and dosage if known:

Check any of the following that contributed to your scheduling an appointment with us:

Emotional/Cognitive

- Feeling nervous, anxious, afraid
- Feeling down, depressed
- Feeling guilty, ashamed
- Dealing with traumatic event
- Thoughts of suicide

Physical

- Chronic/terminal illness/pain
- Panic attacks
- Sleep problems/fatigue
- Poor appetite/Over appetite
- Weight gain/loss

Relationships

- Family concerns
- Relationship issues
- Rejection/Loneliness



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School/Work

- ___ Procrastination
- ___ Skipping class
- ___ Time management

Behaviors

- ___ Attempting suicide
- ___ Binge drinking
- ___ Using drugs
- ___ Withdrawing socially
- ___ Anger/aggression problems
- ___ Self-injury (cutting, burning)

Please list any past, present or impending problems in your *immediate family* (deaths, frequent moves, physical/sexual abuse, financial crisis, psychological history, etc): _____

Have you ever been **hospitalized for psychiatric reasons**? When, where, and why: _____

Have you ever thought about or **inflicted harm on yourself**? Yes No

If yes how long ago? _____

Are you currently thinking about **suicide or harming yourself**? Yes No

Have you had these thoughts in the past? Frequently Sometimes Rarely Never

Are you currently considering **harming another**? Yes No

Have you ever experienced **sexual assault**? Frequently A few times Once Never

Have you ever experienced any other sort of trauma? Yes No; Describe: _____

If applicable, number of alcoholic beverages per week: _____

Have you used any illicit substances in the past two months? Yes No

Have you experienced any alcohol or drug-related problems? Yes No

Do you feel like you struggle with:

Gambling? Yes No

Pornography use? Yes No

Internet use? Yes No

Too much social media? Yes No

What are the **main goals** you would like to see accomplished in counseling?

Is there anything else that you believe would be beneficial for your counselor to know about you?

Student Signature

Date