Amarillo College Counseling Center Intake Packet

The following information is needed to best serve you. Please clearly *print* your response to each question.

SECTION I: IDENTIFYING INFORMATION

Today's Date ________ Name ____ Student ID___________
Date of Birth _________________ Age ____ Sex________ Gender ________ Ethnicity __________________
Address____ State________ Zip ______________
Phone/Cell_______________________________________ Email ____
Best way to reach you □ Phone □ Email
Emergency Contact (spouse, parent, or close relative) _________________________________
Relationship ___________________________ Emergency Contact Phone Number__________________
Are you a part time or full time student? __________________________ Approximate GPA _____________
Field of Study __________________________________ Years at AC ___ Anticipated Graduation Date _____
Military experience/involvement____
Current Employer ____ # Hours Worked/Week ________________
Health Insurance Carrier: ____
How did you hear about the counseling center: ____

SECTION 2: CURRENT CONCERNS

Briefly describe the current concerns you would like to discuss with your counselor:

____
____
____
____

I have had problems recently with the following (check all that apply):

□sleeping □fatigue □appetite □self-worth
□withdrawing □hopeless □anxiety/worry □panic attacks
□concentration □depression □academic problems □financial concerns
□impulsive behavior □weight loss/gain □angry outbursts □hallucinations
□mood shifts □obsessive thoughts □suicidal thoughts □violent thoughts
□self-injurious behaviors (e.g. cutting) □religious/spiritual questioning

Please circle the number that estimates how much these problems are affecting the following aspects of your life:

	Not at all	Slightly	Moderately	Greatly
Ability to Continue in Classes	**1**	**2**	**3**	**4**
Academic Performance	**1**	**2**	**3**	**4**
Relationship with Others	**1**	**2**	**3**	**4**
Emotional Wellbeing	**1**	**2**	**3**	**4**

SECTION 3: MEDICAL HISTORY

Have you had any serious illness, physical problems or injuries? □No □Yes
If yes, what?

Are you currently taking any medication/supplements? □No □Yes
If yes, what (include dosage and frequency)?

Purpose of medication:

Past medications:

Current physician's name:

Current psychiatrist? □ No □ Yes If yes, name:

Have you ever seen a counselor? □No □Yes (if yes, when and for what purpose)

Have you ever been hospitalized for psychiatric concerns? □ No □ Yes (when and for what purpose?)

Have you ever been diagnosed with a mental illness? □No □Yes (if yes, by whom? When? What diagnosis was given?)

SECTION 4: FAMILY HISTORY

Someone in my family has struggled with the following (check all that apply):
□depression □anxiety □bipolar disorder □alcoholism
□drug abuse □physical abuse □sexual abuse □emotional abuse
□eating disorders □suicidal behavior □long term / serious illness □psychiatric hospitalization

Please list who in your family has/had struggled with each issue and any additional information about any boxes that were checked:

Spouse (or significant other's) Name ____________________ Years together ______ □ Not Applicable
How is your relationship:

Have you had a previous marriage or significant relationship: □ No □ Yes
If yes, with whom and how long were you together? What was the cause of the separation:

Children □ Not Applicable

Name________________________________ Age ________Grade ________
Name________________________________ Age________ Grade ________
Name ________________________________Age________ Grade ________

Describe the relationship with your children:

Parents
Mother's Name _________________________ ☐ Birth ☐Step ☐Adopted
Describe your relationship:
____

Mother's Name _________________________ ☐ Birth ☐Step ☐Adopted
Describe your relationship:
____

Father's Name _________________________ ☐ Birth ☐Step ☐Adopted
Describe your relationship:
____

Father's Name _________________________ ☐ Birth ☐Step ☐Adopted
Describe your relationship:
____

SECTION 5: HOME ENVIRONMENT

Who are you currently living with:
____

Describe the physical, social, and emotional environment in your present living space:
____
____
____

SECTION 6: PERSONAL INFORMATION

Alcohol Use
Do you drink alcohol?
☐ No (skip to next section) ☐ Yes (answer questions below)

1. How often do you have a drink containing alcohol?
   ☐ Monthly or Less ☐ 2-4 times/month ☐ 2-3 times/week ☐ 4 + times/week
2. How many drinks do you typically have when drinking?
   ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7 or more
3. How often do you have six or more drinks on one occasion?
   ☐ Never ☐ Monthly or Less ☐ 2-4 times/month ☐ 2-3 times/week ☐ 4+ times/week
4. Have you ever experienced a blackout due to alcohol?
   ☐ No ☐Yes
5. Has alcohol ever affected your sexual health?
   ☐ No ☐ Yes

Tobacco and Other Drug Use
Do you use tobacco?
☐ No (skip to next section) ☐ Yes (answer questions below) ☐ History of Use (year quit _____)
Number of years using tobacco ______
☐ Cigarettes - #/day ____ ☐ Chew - #/day_____ ☐ Vaping - #/day _____ ☐ Cigars - #/day _____
Have you tried to quit? ☐ Once ☐ More than once ☐ Planning to quit ☐ No plan to quit

Please check the recreational drug(s) you currently use or have used in the past:
☐ None ☐ Marijuana ☐ Cocaine ☐ Stimulants ☐ Ecstasy
☐ Kratom ☐ Bath Salts ☐ Opiates (Percocet, Oxy, etc.) ☐ Heroin
☐ Hallucinogens (LSD, mushrooms, PCP, etc.) ☐ Other ____________
Have you ever been through a substance rehabilitation program? ☐ No ☐ Yes
If yes, when and where? ____

Abuse History
Have you ever suffered from being abused? ☐No (skip to next section) ☐ Yes
If yes, what kind of abuse have you suffered? ☐ Mental/Emotional ☐ Verbal ☐ Sexual ☐ Physical
If you are comfortable, please briefly describe when the abuse took place and what occurred:

____
____
____
____
____
____

Disordered Eating
Are you satisfied with your eating patterns? ☐No ☐ Yes
Do you ever eat in secret? ☐No ☐ Yes
Does your weight affect the way you feel about yourself? ☐No ☐ Yes
Do you currently suffer with or have you ever suffered with an eating disorder? ☐No ☐ Yes

Sleeping
How many hours of sleep do you typically get? _______
How long does it take you to fall asleep? _________________________
How many times do you typically wake up during the night? _________
Do you wake up feeling rested? ☐No ☐Yes

Legal Involvement
Have you ever been in trouble with the legal system? ☐No ☐Yes
If yes, please describe what happened and when it happened:

____
____
____

Suicide
Do you currently or have you ever had suicidal thinking? ☐ No ☐ Yes, currently ☐ Yes, in the past
If yes, have you made of plan of how you would kill yourself? ☐ No ☐ Yes
Do you trust yourself not to act on these thoughts? ☐ No ☐ Yes

Self Harm
Have you ever intentionally harmed yourself? ☐ No ☐ Yes
If yes, how? When did it first occur? When was the last time you self-harmed?

____
____

Financial Well-being
Do you have adequate food/clothing/shelter? ☐No ☐Yes
How would you describe your current financial situation?

____
____

SECTION 7: SUPPORT AND STRENGTHS

Support
Do you have friends? ☐ No ☐ Yes
Do you feel supported by your family? ☐ No ☐Yes
Do you have people you can confide in? ☐ No ☐ Yes
Do you feel that your professors care about you? ☐ No ☐ Yes

Strengths

What are your personal strengths?

What gives you hope?

What do you want to gain from counseling?