Parkland College | Counseling Services | Counseling Intake Form

Today's Date:	First Name:	Last Name:	Preferred Name:

Preferred Pronoun:	Date of Birth:	Age:	Parkland I.D.:	Cell Phone:	OK to call?
					☐

Home Phone:	OK to call?	Preferred Email:	OK to email?
	☐		☐

Local Address: (OK to contact you at home? ☐)
Street:
City:
State/ZIP:

Permanent Address:
Street:
City:
State/ZIP:

Emergency Contact Person:
Relationship to You:
Telephone:

What is your primary reason for seeking assistance? Please Describe:

Does the reason for seeking assistance today involve any of the following? Please check any that apply.

- ☐ Concerned about alcohol or drug use. Please describe:
- ☐ Discrimination/hate crime
- ☐ Loss/death of a significant person
- ☐ Harassment/stalking
- ☐ Physical or emotional abuse
- ☐ Sexual assault, past or current sexual abuse
- ☐ Thoughts of harming myself or another person
- ☐ Have deliberately injured myself
- ☐ Academic performance. Please describe:

How often in the past year have you had more than (5 drinks in a day if you are male) (4 drinks in a day if you are female)? ☐ Never ☐ 1 or More Times	**How often in the past year have you used a recreational drug or used a prescription medication for non-medical reasons?** ☐ Never ☐ 1 or More Times

Please list any previous or current mental health therapy and any previous hospitalizations:

Provider/Clinic:	Condition/Issue:	Date(s):

Please list any health concerns:

Please list any current medications (psychiatric, medical, and over-the-counter):

Medication:	Reason for Taking:

How would you describe your eating patterns (do you have an adequate food source)?

How would you describe your sleeping patterns?

Gender: Please check the appropriate box or fill in below: ☐ Male ☐ Female ☐ Transgender ☐ Non-Binary ☐ Fluid ☐ My description (please fill in): ☐ Prefer Not to Answer	**Sexual Orientation**: Please check the appropriate box or fill in below: ☐ Asexual ☐ Bisexual ☐ Gay ☐ Hetero ☐ Questioning ☐ My description (please fill in): ☐ Prefer Not to Answer

Primary Insurance or Behavioral Health Insurance Provider: (☐ Not applicable)

Provider:	Provider Phone #:
Member ID#:	Group #:

Counselor Preferences:

Do you have a gender preference for your assigned counselor?	☐ Male ☐ Female ☐ No preference
Do you have a specific counselor with whom you would like to work?	☐ No ☐ Yes Counselor name:
Do you have a preference for the race/ethnicity of your assigned counselor?	☐ No ☐ Yes My preference is:

Appointment Availability:
Indicate the best days and times that do not interfere with your class or work schedule. Please allow 50 minutes in your schedule for a counseling appointment.

		AM | 8 a.m. to 12 p.m.	**PM** | 12 to 4 p.m.
MONDAY	No availability		
TUESDAY	No availability		
WEDNESDAY	No availability		
THURSDAY	No availability		
FRIDAY	No availability		