|  |  |  |  |
| --- | --- | --- | --- |
| **Today’s Date:** | **First Name:** | **Last Name:** | **Preferred Name:** |
|  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Preferred Pronoun:** | **Date of Birth:** | **Student I.D.:** | **Parkland Email:** | **OK to email?** |
|  |  |  |  | ☐ |

|  |  |
| --- | --- |
| **Gender**: Please check box or fill in:  Male  Female  Transgender  Fluid  Non-Binary  Prefer Not to Answer  My own description: | **Sexual Orientation**: Please check box or fill in:  Asexual  Bisexual  Gay  Hetero/straight  Questioning  Prefer Not to Answer  My own description: |

|  |  |  |  |
| --- | --- | --- | --- |
| **Cell Phone:** | **OK to call?** | **Home Phone:** | **OK to call?** |

|  |  |
| --- | --- |
| **Local Address: (OK to contact you at home?)** | **Permanent Address:** |
| Street: | Street: |
| City: State/ZIP: | City: State/ZIP: |

|  |  |
| --- | --- |
| **Emergency Contact Person:** | **Relationship to You:** |
| **Phone:** | |

**What is your main reason for seeking assistance? Please Describe:**

|  |
| --- |
|  |

**Other issues: (Please check all that apply):**

Concerned about alcohol/drug use Past  Present

Discrimination/hate crime Past  Present

Loss/death of a significant person Past  Present

Harassment/stalking Past  Present

Physical or emotional abuse Past  Present

Sexual assault, past or current sexual abuse Past  Present

Thoughts or actions on harming myself Past  Present

Thoughts of harming another person Past  Present

Academic performance Past  Present

|  |  |
| --- | --- |
| **Interested in Group Counseling** |  |
| **Interested in One-on-one Counseling** |  |

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

|  |  |  |
| --- | --- | --- |
| Provider/Clinic | Condition/Issue | Date(s) |
|  |  |  |
|  |  |  |
|  |  |  |

**Please list any physical 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?**

|  |
| --- |
|  |

|  |  |
| --- | --- |
| 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 |

|  |  |
| --- | --- |
| Do you have a specific counselor with whom you would like to work? | No  Yes, name of preferred counselor: |

**Days/Times you are Available:** (Make sure they don’t conflict with classes/work). Appointments scheduled for 50min

|  |  |  |
| --- | --- | --- |
|  | **AM (8-12)** | **PM (12-4)** |
| Monday |  |  |
| Tuesday |  |  |
| Wednesday |  |  |
| Thursday |  |  |
| Friday |  |  |