|  |  |  |  |
| --- | --- | --- | --- |
| **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 |  |  |