Jefferson Center at Red Rocks Community College

Demographic Information

Name_____**Preferred Pronoun (He/She/They/Other)** _____**Date**_____

Student ID _____ **DOB**_____/_____/_____ **Age**_____

Referred by _____ **Primary Language** _____

Military Service Member: Y / N Military Veteran: Y / N **Military Branch:** _____ **TRIO SSS Grant Recipient:** Y / N

Contact Information

Address _____

City_____**County**_____**State**_____**Zip**_____

Primary Phone _____**Secondary Phone** _____ □ **Ok to contact by phone**

Email _____ □ **Ok to contact by email**

Emergency Contact

Name _____ **Relationship** _____**Phone**_____

Address _____

Student Status

Years of Education _____ **Cumulative GPA**_____ **Number of credit hours this semester**_____

RRCC Program of Study _____ **Career Goals** _____

Demographic Information (optional, but appreciated for funding purposes)

Sex: M/ F/ I **Gender:** M / F/ T/ Other: _____ **Sexual Orientation:** G/ L/ B/ H/ Other: _____

Relationship Status □ Single □ Married □ Partnered □ Separated □ Divorced □ Other _____

Cultural Background Ethnicity

□ **Black/African American** _____

□ **American Indian/ Alaska Native (Nation)** _____

□ **Asian Indian (specify)** _____

□ **Asian (specify)** _____

□ **Hawaiian/ Pacific Islander (Specify)**_____

□ **Hispanic/ Latino (Specify)** _____

□ **International Student (Specify)**_____

□ **Mixed ancestry or unlisted** _____

□ **White/ European American**_____

Financial Information:

Annual Income _____**Other Income**_____**Hrs worked/ wk** _____ **Dependents** _____

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Medical Insurance

Y / N **Provider Name:**		**ID #**		**Group #**	
Y / N	**Medicare**	**ID #**		**Group #**	
Y / N	**Medicaid**	**ID #**		**Group #**	

Medical History (Please mark and specify all that apply)

□ **Allergies**		□ **Disabilities**	
□ **Chronic Conditions**		□ **High Blood Pressure**	
□ **Current Alcohol/Substance Abuse**		□ **Life Threatening Conditions**	
□ **Current Medications**		□ **Traumatic Brain Injury**	
□ **Diabetes**		□ **Other Conditions**	

Tobacco Use: □ Never Smoked □ Smoked in past, but quit □ Current smoker □ Current smoker, but want to quit

Medical and Other Providers

Primary Care Physician_____ **Phone** _____

Date of Last Medical Visit _____ **Reason for Visit** _____

Mental Health History

Psychiatrist_____ **Dates of Care** _____

Previous Counselor_____ **Dates of Care** _____

Previous Psychiatric Hospitalization _____ **Dates of Care** _____

Previous Medications _____

History of Issues (Please mark all that apply)

- □ **Eating Disorders**
- □ **Fetal Alcohol/ Drug Exposure**
- □ **Intimate Relationship Violence**
- □ **Sexual Misconduct**
- □ **Victim of Phys/Sexual Trauma**
- □ **Drug/ Alcohol Abuse**
- □ **Legal Convictions**
- □ **Self-Injury (date of most recent:)**
- □ **Suicide Attempt (date of most recent:)**
- □ **Lived in Violent Environment**

Suicidal Thoughts

- □ **I am currently having suicidal thoughts**
- □ **I have had suicidal thoughts in the past two weeks**
- □ **I have had suicidal thoughts in the past 3 months**
- □ **I have had suicidal thoughts in the past, but not in the last 3 months**
- □ **I have never had suicidal thoughts**

What are the problems you would like to address in counseling? Please mark all that apply.

□ **Anxiety**	□ **Attention**	□ **Anger**	□ **Bi-polar symptoms**
□ **Depression**	□ **Eating**	□ **Grief**	□ **Mood Swings**
□ **Phys/Sex Abuse**	□ **Relationships**	□ **Sexual Identity**	□ **Sleeping**
□ **Social**	□ **Alcohol/Subst Abuse**	□ **Trauma**	□ **Housing/Living Problem**
□ **Self Injury**	□ **Medication Options**	□ **Other (Specify):**	

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Symptom Checklist

Please share the most concerning symptom/problem that you would like to address at this time:

_____

_____

Please check all that apply

- ☐ Anhedonia
- ☐ Change in appetite
- ☐ Change in sleep
- ☐ Decreased appetite/weight loss
- ☐ Decreased concentration
- ☐ Decreased energy/fatigue
- ☐ Depressed mood
- ☐ Difficulty falling asleep
- ☐ Difficulty with Activities of Daily Living
- ☐ Early morning awakening
- ☐ Excessive/inappropriate guilt
- ☐ Feelings of hopelessness
- ☐ Feelings of worthlessness
- ☐ Hypersomnia (sleeping too much)
- ☐ Increase appetite/weight gain
- ☐ Irritability
- ☐ Body agitation
- ☐ Body retardation
- ☐ Recurrent thoughts of death/suicidal ideation
- ☐ Sleep interruption/disturbance
- ☐ Tearfulness

- ☐ Abnormally/persistent elevated mood
- ☐ Abnormal and persistent irritability
- ☐ Hyperactivity/increase energy
- ☐ Inflated self-esteem/Grandiosity
- ☐ Decreased need for sleep
- ☐ Pressured Speech
- ☐ Flight of ideas (racing thoughts)
- ☐ Distractibility
- ☐ Increased goal-directed activity
- ☐ Body agitation
- ☐ Impulsivity

- ☐ Hallucinations
- ☐ Auditory
- ☐ Visual
- ☐ Command
- ☐ Delusions
- ☐ Ideas of reference
- ☐ Paranoia
- ☐ Problems with thought formation
- ☐ Disorganized speech
- ☐ Grossly disorganized/bizarre behavior
- ☐ Catatonic behavior
- ☐ Negative symptoms
- ☐ Alogia (inability to speak)
- ☐ Avolition (lack of motivation)
- ☐ Flat or inappropriate affect
- ☐ Social withdrawal/isolation

- ☐ Obsessive thoughts
- ☐ Compulsive behavior
- ☐ Body Dysmorphia
- ☐ Trichotillomania (hair-pulling)
- ☐ Excoriation (skin-picking)

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- ☐ Anxiety last throughout the day
- ☐ Being easily fatigued
- ☐ Chest pain or discomfort
- ☐ Chills or heat sensations
- ☐ Choking sensations
- ☐ Depersonalization
- ☐ De-realization
- ☐ Discrete periods of intense panic
- ☐ Fear of dying
- ☐ Fear of losing control/"going crazy"
- ☐ Feeling dizzy, light-headed, or faint
- ☐ Irritability
- ☐ Muscle tension
- ☐ Nausea/abdominal distress
- ☐ Palpitations/accelerated heart rate
- ☐ Paresthesia (numbness/tingling)
- ☐ Physical symptoms of panic
- ☐ Restlessness, feeling keyed-up/on-edge
- ☐ Shortness of breath/smothering
- ☐ Sleep disturbance
- ☐ Sweating
- ☐ Trembling/shaking
- ☐ Trouble concentrating/mind going blank

- ☐ Avoidance of trauma related memories/thoughts/external reminders
- ☐ Diminished interest/participation in significant activities
- ☐ Disinhibited Social Engagement Symptoms
- ☐ Dissociation/flashbacks
- ☐ Dreams w/out recognizable content
- ☐ Exaggerated startled response
- ☐ Feeling of detachment/estrangement from others
- ☐ Hypervigilance
- ☐ Inability to remember important aspects of trauma
- ☐ Intense/prolonged distress at exposure to trauma cues
- ☐ Irritable behavior/angry outbursts
- ☐ Persistent cognitive distortions leading to blame of self/others
- ☐ Persistent inability to experience positive emotion
- ☐ Persistent negative emotional state
- ☐ Persistent/exaggerated negative beliefs about self/others/world
- ☐ Physiological reactions to trauma cues
- ☐ Problems with concentration
- ☐ Reactive Attachment symptoms
- ☐ Reckless/self-destructive behavior
- ☐ Recurrent distressing dreams w/trauma related content/affect
- ☐ Recurrent intrusive thoughts/memories
- ☐ Sleep disturbance
- ☐ Trauma-specific play/reenactment

- ☐ Appears driven to move/often "on the go"
- ☐ Avoids tasks requiring sustained effort
- ☐ Blurts out responses
- ☐ Difficulty completing chores
- ☐ Difficulty awaiting turn
- ☐ Difficulty focusing/sustaining attention
- ☐ Difficulty organizing tasks/activities
- ☐ Difficulty with quiet activities
- ☐ Easily distracted by extraneous stimuli
- ☐ Fidgeting
- ☐ Frequently loses necessary items
- ☐ Inattention (mistakes/overlooks details)
- ☐ Interrupts/intrudes on others
- ☐ Leaves seat inappropriately
- ☐ Often forgetful in daily activities'
- ☐ Often talks excessively
- ☐ Poor follow Through
- ☐ Runs, climbs excessively (restlessness)
- ☐ Difficulty completing schoolwork
- ☐ Seems not to listen
- ☐ Difficulty completing work tasks

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