***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 \_\_\_\_\_**

**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** | ***□*** | **Drug/ Alcohol Abuse** |
| ***□*** | **Fetal Alcohol/ Drug Exposure** | ***□*** | **Legal Convictions** |
| ***□*** | **Intimate Relationship Violence** | ***□*** | **Self-Injury (date of most recent: )** |
| ***□*** | **Sexual Misconduct** | ***□*** | **Suicide Attempt (date of most recent: )** |
| ***□*** | **Victim of Phys/Sexual Trauma** | ***□*** | **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 never had suicidal thoughts** | **□ I have had suicidal thoughts in the past, but not in the** **last 3 months** |

***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):** |

**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)
 |

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