

**UNIVERSITY OF WASHINGTON BOTHELL STUDENT COUNSELING SERVICES
INTAKE FORM**

Updated 6/2007

Today's Date: _____

Please fill in the following background information:

Name _____ Student Number _____
Last First MI E-mail address _____

Date of birth _____ Age _____ Sex _____ Veteran? Yes _____ No _____

Address _____ City _____ Zip _____

Home phone () _____ Cell Phone () _____ Work phone () _____

MESSAGES: Okay to leave message at home? _____ On cell phone? _____ At work? _____ (message will NOT mention the Student Counseling Center)

Are you currently enrolled at UW Bothell? Yes _____ No _____ How many credits are you taking this quarter? _____

Will you be enrolled at UW Bothell next quarter? Full-time _____ Part-time _____ Not at all _____

Cumulative UW GPA _____ Major Field of Study _____ Concentration _____ GPA _____

Transfer Student _____ Previous College(s) _____ Dates Attended _____ GPA _____

<u>Referral Source</u>	<u>Classification</u>	<u>Ethnicity (optional)</u>	<u>Relationship Status</u>
_____ Self	_____ Freshman	_____ African American	_____ Single
_____ Friend	_____ Sophomore	_____ Asian American	_____ Married
_____ UW Faculty/Staff	_____ Junior	_____ Hispanic American	_____ Separated
_____ Family	_____ Senior	_____ Alaskan Native/	_____ Divorced
_____ Other (specify)	_____ Graduate	_____ Native American	_____ In committed
_____	_____ Non-matriculated	_____ Caucasian American	_____ relationship
_____	_____ International Student	_____ Other: _____	_____ Ages of children

Have you ever been seen at the University of Washington Bothell Student Counseling Center before? Yes _____ No _____

If so, when? _____

Are you presently seeing another counselor/therapist? Yes _____ No _____

If so, please indicate who _____

Have you previously received psychological counseling elsewhere? Yes _____ No _____

When, where, and with whom? _____

Are you currently taking prescribed medication? Yes _____ No _____ If so, what? _____

Daily dose _____ Purpose of medication _____

Physician prescribing medication _____ Phone _____

Have you previously been prescribed medication for mental health concerns? Yes _____ No _____

If so, what? _____

Alcohol intake: none _____ occasional _____ drinks/day _____ drinks/week _____

Recreational drug use: none _____ occasional _____ weekly _____ daily _____

FAMILY EXPERIENCES

Instructions:

Below is a list of experiences that may occur in families. Read each item carefully. Some of these may have been true at one point in your life but not true at another point. If the experience ever happened in your family, either to you or someone else, please check the space corresponding to "YES." If the experience never happened in your family, please check the space corresponding to "NO". If you are unsure whether or not the experience occurred in your family at some time, please check "UNSURE".

	YES	NO	UNSURE
1. Parents divorced or permanently separated.....	_____	_____	_____
2. Family frequently moved.....	_____	_____	_____
3. Parent(s) unemployed for an extended period of time.....	_____	_____	_____
4. Frequent, hostile arguing among family members.....	_____	_____	_____
5. Death of parent(s).....	_____	_____	_____
6. Family member with a drinking problem.....	_____	_____	_____
7. Family member with a drug problem.....	_____	_____	_____
8. Family member with a gambling problem.....	_____	_____	_____
9. Physical abuse in your family.....	_____	_____	_____
10. Sexual abuse in your family.....	_____	_____	_____
11. Rape/sexual assault of yourself or family member.....	_____	_____	_____
12. Family member hospitalized for emotional problems.....	_____	_____	_____
13. Family member with an emotional problem.....	_____	_____	_____
14. Family member diagnosed with a mental disorder.....	_____	_____	_____
15. Family member attempted suicide.....	_____	_____	_____
16. Family member committed suicide.....	_____	_____	_____
17. Family member with a debilitating illness, injury, or handicap.....	_____	_____	_____
18. Family member prosecuted for criminal activity.....	_____	_____	_____
19. Family member with an eating problem.....	_____	_____	_____

(Continued on next page)

PRESENTING PROBLEMS

INSTRUCTIONS:

Below is a list of problems people sometimes face. Please respond to each item. For those concerns you are currently experiencing, please note the duration of current concern and the amount of distress.

	<u>History of Concern</u>			<u>Duration of Current Concern</u>				<u>Amount of Distress</u>		
	CURRENT	PAST	NEVER	LESS THAN ONE MONTH	1-6 MONTHS	6-12 MONTHS	MORE THAN ONE YEAR	MILD	MODERATE	SEVERE
1. Academics/schoolwork/grades	—	—	—	—	—	—	—	—	—	—
2. Adjustment to UW Bothell	—	—	—	—	—	—	—	—	—	—
3. Alcohol/drug use	—	—	—	—	—	—	—	—	—	—
4. Anxiety, fear, worries, nervousness	—	—	—	—	—	—	—	—	—	—
5. Assertiveness, standing up for yourself	—	—	—	—	—	—	—	—	—	—
6. Breakup/loss of a relationship	—	—	—	—	—	—	—	—	—	—
7. Concentration	—	—	—	—	—	—	—	—	—	—
8. Confusion about beliefs/values	—	—	—	—	—	—	—	—	—	—
9. Death/impending death of significant person	—	—	—	—	—	—	—	—	—	—
10. Decisions about career/major	—	—	—	—	—	—	—	—	—	—
11. Depression	—	—	—	—	—	—	—	—	—	—
12. Developing independence from your family	—	—	—	—	—	—	—	—	—	—
13. Discrimination	—	—	—	—	—	—	—	—	—	—
14. Distrust of others	—	—	—	—	—	—	—	—	—	—
15. Eating problems:										
a. binging & vomiting/diet/use of laxatives	—	—	—	—	—	—	—	—	—	—
b. fasting/avoiding food	—	—	—	—	—	—	—	—	—	—
c. overeating	—	—	—	—	—	—	—	—	—	—
16. Fear of "going crazy"	—	—	—	—	—	—	—	—	—	—
17. Feelings of guilt/shame	—	—	—	—	—	—	—	—	—	—
18. Finances	—	—	—	—	—	—	—	—	—	—
19. Homesickness	—	—	—	—	—	—	—	—	—	—
20. Irritability, anger, hostility	—	—	—	—	—	—	—	—	—	—
21. Lack of relationship	—	—	—	—	—	—	—	—	—	—
22. Loneliness/isolation	—	—	—	—	—	—	—	—	—	—
23. Making friends	—	—	—	—	—	—	—	—	—	—
24. Overly sensitive	—	—	—	—	—	—	—	—	—	—
25. Perfectionism	—	—	—	—	—	—	—	—	—	—
26. Physical concerns	—	—	—	—	—	—	—	—	—	—
27. Pregnancy	—	—	—	—	—	—	—	—	—	—
28. Preoccupied with recurring thoughts/feelings	—	—	—	—	—	—	—	—	—	—
29. Procrastination/getting motivated	—	—	—	—	—	—	—	—	—	—
30. Rape/sexual assault/unwanted sex	—	—	—	—	—	—	—	—	—	—
31. Relationship with family/parents/siblings	—	—	—	—	—	—	—	—	—	—
32. Relationship with friends/roommates/peers	—	—	—	—	—	—	—	—	—	—
33. Relationship with romantic partner/spouse	—	—	—	—	—	—	—	—	—	—
34. Religious/spiritual concerns	—	—	—	—	—	—	—	—	—	—
35. Self-esteem/self-confidence	—	—	—	—	—	—	—	—	—	—

(Continued on next page)

History of Concern Duration of Current Concern Amount of Distress

CURRENT PAST NEVER	LESS THAN ONE MONTH 1-6 MONTHS 6-12 MONTHS MORE THAN ONE YEAR	MILD MODERATE SEVERE
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36. Sexual abuse	_	_	_	_	_	_	_	_	_	_
37. Sexual concerns	_	_	_	_	_	_	_	_	_	_
38. Sexual harassment	_	_	_	_	_	_	_	_	_	_
39. Sexual identity/gay/lesbian issues	_	_	_	_	_	_	_	_	_	_
40. Shyness, being ill at ease with people	_	_	_	_	_	_	_	_	_	_
41. Sleeping problems	_	_	_	_	_	_	_	_	_	_
42. Stress management	_	_	_	_	_	_	_	_	_	_
43. Suicidal feelings/thoughts	_	_	_	_	_	_	_	_	_	_
44. Test anxiety/speech performance anxiety	_	_	_	_	_	_	_	_	_	_
45. Thoughts of death or dying	_	_	_	_	_	_	_	_	_	_
46. Time management	_	_	_	_	_	_	_	_	_	_
47. Uncertain about future/life after university	_	_	_	_	_	_	_	_	_	_
48. Weight problems/body image	_	_	_	_	_	_	_	_	_	_
49. Other _____	_	_	_	_	_	_	_	_	_	_
50. Other _____	_	_	_	_	_	_	_	_	_	_

1. If you are here for an intake, what is/are the primary concern(s) you would like to discuss with your counselor?

2. List three goals you would most like to achieve through our services:

(1)

(2)

(3)