**Student Health and Wellness K#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Santa Barbara City College**

**721 Cliff Drive, Santa Barbara, CA 93109 Age: \_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_**

**(805) 965-0581 Ext. 2298 • Fax (805) 560-6572**

**Mental Health Intake Form**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Gender Pronoun:** 🞏 **He/Him/His** 🞏 **She/Her/Hers** 🞏 **They/Them/Theirs** 🞏 **Other: \_\_\_\_\_\_\_\_\_\_**

**Address/City/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone # ( ): \_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell # ( )\_\_\_\_\_\_\_\_\_\_\_\_ E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***May we phone you? Yes 🞏 No 🞏 Leave a message? Yes 🞏 No 🞏 May we email you? Yes 🞏 No 🞏***

**Primary Language: 🞏 English 🞏 Spanish 🞏 Bilingual 🞏 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Ethnicity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Current Gender Identity: 🞏 Man 🞏 Woman 🞏 Transgender (M to F or F to M) 🞏 Genderqueer 🞏 Other**

**Sexual Orientation: 🞏 Heterosexual 🞏 Gay/Lesbian🞏 Bisexual 🞏 Decline to state 🞏 other: \_\_\_\_\_\_\_\_\_**

**Emergency contact name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ph. # ( ): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address/City/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CURRENT CONCERNS:**

Please list the major issues or concerns that you would like to discuss and then, rate the severity of each one based on the following scale: **0---1---2---3---4---5---6—7—8---9---10** (1= low, 5=moderate, 10= severe)

|  |  |
| --- | --- |
| Concerns | Rating |
| 1. |  |
| 2. |  |
| 3. |  |

What motivated you to come to counseling now, rather than sometime earlier, or later? Did someone refer you to our services?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What do you hope to get from coming to counseling?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How do you currently cope or try to cope with your main concerns?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SAFETY CONCERNS:**

1. Are you having suicidal thoughts or thoughts of harming yourself? 🞏 No 🞏 Yes
2. Are you having thoughts of hurting someone else? 🞏No 🞏 Yes
3. Have you had a history of suicide attempts or self-harm? 🞏 No 🞏 Yes If so, when? ­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ACADEMIC STATUS:**

1. In the past month has your academic performance 🞏 improved 🞏 stayed the same 🞏 gotten worse
2. Rate the relationship of your academic performance to the concerns that brought you in today. (1= not related 5= very related) \_\_\_\_\_\_\_
3. Due to the impact of your concerns, are you considering any of the following?

🞏 Talking to instructors 🞏 dropping a class 🞏 withdrawing from the semester 🞏 leaving college

1. How many units are you taking this semester? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Academic Goals: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CURRENT HEALTH STATUS:**

1. Current or chronic health problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Do you have a prior history of counseling, mental health treatment, hospitalization, or alcohol/mental health rehab? If yes, please describe.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Has anyone in your family had problems or been treated for:

 🞏 Depression 🞏 Anxiety 🞏 Learning Difficulties 🞏 Alcohol/drug use 🞏 other mental illness 🞏 N/A

1. Are you currently receiving mental health counseling or therapy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Are you currently taking psychiatric medication? If so, what type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Prescribing Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. How many hours a night are you sleeping? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you experience any of the following: 🞏 Never feel well-rested 🞏 Difficult falling asleep 🞏 Often wakeful at night 🞏 Waking up to early 🞏 Other
4. Exercise habits: Usually exercise \_\_\_\_ days per week, type of exercise: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 🞏 Do not exercise regularly

1. Stress Level:Rate you stress level 1-5 (1 = no stress 5 = very high stress):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. What do you do to reduce stress? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Eating Patterns: How many meals a day do you have? \_\_\_\_\_\_\_\_
4. Do you: 🞏 Often skip meals 🞏 Often eat fast food or prepared food 🞏 Have a history of eating concerns/issues 🞏 Have dietary restrictions if so, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SUBSTANCE USE:**

1. Have you ever felt you should cut down on your use of alcohol or other drugs? 🞏 Yes 🞏 No
2. Have people annoyed you by criticizing your drinking or using? 🞏 Yes 🞏 NO
3. Have you ever felt bad or guilty about your drinking or using? 🞏 Yes 🞏 NO
4. Have you ever had a drink or used a substance first thing in the morning? 🞏 Yes 🞏 NO
5. Have you experienced blackouts or trouble remembering due to your drinking or using? 🞏 Yes 🞏 NO

**GENERAL LIFE:**

1. What are your strengths?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Are you currently utilizing other services on campus? (ie: EOPS, DSPS, Wellness connection, etc.)

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1. Do you have a job, internship, or other responsibilities? What do you do and for how many hours weekly?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Rate your support system level 1-5 (1= strong support from family & friends 5= isolated and lonely): \_\_\_\_\_\_
2. Circle your “sense of life purpose” on this scale: **1 -2- 3- 4- 5** (1= emptiness/loss of meaning of life 5= strong sense of self purpose)
3. Who do you feel supported by? (ie. Friends, family, teachers, mentors, etc)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Relationship Status: ­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_