SBCC Anchor Program
Student Health and Wellness
Santa Barbara City College
721Cliff Drive, Santa Barbara, CA 93109
(805) 965-0581 Ext. 2298 • Fax (805) 560-6572

Name: _____
K#: _____

Anchor Program 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? _____

GENERAL INFORMATION:

1. Are you in Recovery? ☐ Yes ☐ No (if Yes, please skip to Treatment History Section)
2. What substance(s) cause you (or have caused) the most problems:
   _____
3. Do you experience physical symptoms when you try to stop using: ☐ Yes ☐ No
   ☐ Shakes/tremors ☐ Sweating/perspiration ☐ Seizures ☐ Continuous Vomiting
   ☐ Sleeplessness ☐ Disorientation ☐ Hallucinations ☐ Other: _____

SUBSTANCE USE HISTORY:

SUBSTANCE	Ever Used?		Ever a Problem?		Age/Year 1st time Regular Use	Use Past 6 mo. Frequency/ Amount	Last Use
Alcohol	Yes	No	Yes	No			
Cannibis/Marijuana	Yes	No	Yes	No			
Nicotine	Yes	No	Yes	No			
Cocaine/Crack	Yes	No	Yes	No			
ADHD Medications (Adderall, Ritalin, Dexadrine, etc)	Yes	No	Yes	No			
Methamphetamine/Amphetamines	Yes	No	Yes	No			
Opiates/Opioids: Heroin, Codeine, Soma, Vicodin, OxyContin, Percodan, Demerol, hydromorphone, Methadone/Suboxone	Yes	No	Yes	No			
Benzodiazepines (Xanax, Ativan, Klonopin, Valium, LIbrium)	Yes	No	Yes	No			
Sleeping Pills (Restoril, Lunesta, Halcion, Ambien)	Yes	No	Yes	No			
LSD	Yes	No	Yes	No			
Mushrooms/Psilocybin	Yes	No	Yes	No			
Ecstasy/MDMA	Yes	No	Yes	No			
DMT/Ayahuasca	Yes	No	Yes	No			
Ketamine	Yes	No	Yes	No			
Bath Salts	Yes	No	Yes	No			
Peyote/Mescaline	Yes	No	Yes	No			
PCP	Yes	No	Yes	No			
Dextromethorphan	Yes	No	Yes	No			
Inhalants: (Nitrous Oxide, dust off, glue)	Yes	No	Yes	No			
Other:	Yes	No	Yes	No			

TREATMENT HISTORY:

1. Do you have any Mental health disorders that are pre-existing, or have been exacerbated by substance use:
   _____
   _____
   _____

TREATMENT HISTORY CONTINUED:

2. Have you been in counseling or treatment before? ☐ Yes ☐ No
   Check all that apply:
   ☐ Hospitalization ☐ Inpatient Treatment Program ☐ Outpatient Treatment Program
   ☐ Private Practitioner (Therapist, Psychologist, Psychiatrist, etc)

Facility/Agency Name: _____ City/State _____ Dates: _____
How long were you there: _____ Did you complete the Program: ☐ Yes ☐ No
How long did you stay abstinent after leaving the program? _____

Facility/Agency Name: _____ City/State _____ Dates: _____
How long were you there: _____ Did you complete the Program: ☐ Yes ☐ No
How long did you stay abstinent after leaving the program? _____

Prior or Current Practitioners:

Name: _____ Name: _____
When: _____ When: _____
How Long: _____ How Long: _____

QUESTIONS RELATED TO SUBSTANCE USE:

1. Do you abuse more than one drug at a time, if so, which ones? ☐ Yes ☐ No
   _____
2. Have you ever felt you should cut down on your use of alcohol or other drugs? ☐ Yes ☐ No
3. Have people annoyed you by criticizing your drinking or using? ☐ Yes ☐ No
4. Have you ever felt bad or guilty about your drinking or using? ☐ Yes ☐ No
5. Have you ever had a drink or used a substance first thing in the morning? ☐ Yes ☐ No
6. Have you ever attended 12 Step, refuge recovery, or SMART recovery meetings? ☐ Yes ☐ No
7. Have you experienced blackouts or trouble remembering due to your use? ☐ Yes ☐ No
8. How much is spent on drugs and/or alcohol:
   Per week: _____ per month: _____

GENERAL LIFE:

1. What are your strengths?
   _____
2. Are you currently utilizing other services on campus? (ie: EOPS, DSPS, The Well, etc.)
   _____
3. Do you have a job, internship, or other responsibilities? What do you do and for how many hours weekly?
   _____
4. Rate your support system level 1-5 (1= strong support from family & friends 5= isolated and lonely): _____
5. 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)
6. Whom do you feel supported by? (ie. Friends, family, teachers, mentors, etc.
   _____
7. Relationship Status: _____