NEW MEXICO TECH
SCIENCE • ENGINEERING • RESEARCH UNIVERSITY

Office of Counseling & Disability Services (OCDS)
NW Fidel 1st floor Room, 150 * Phone: 575-835-6619 * Fax: 575-835-6001
www.nmt.edu/counseling-servics counseling@nmt.edu
HOURS: 8:00am to 5:00pm Monday – Friday

COUNSELING INTAKE PACKET

WHO IS ELIGIBLE FOR SERVICES:

- Students who are currently enrolled

INFORMED CONSENT/CONFIDENTIALITY NOTICE:

The State of New Mexico legally recognizes that communication between a counselor and his/her client is privileged and confidential. We will not disclose your contacts with us to your spouse/partner, your parents, professors, or anyone else without your permission. There are few narrow exceptions:

- If you are in imminent danger to yourself or are a significant danger to someone else, we have a legal obligation to break confidentiality to protect you and/or others.
- Your records can also be subpoenaed by a court of law (e.g. if you claimed emotional damages in a lawsuit).
- If you are abusing children or vulnerable adults or inform us concerning someone who is, then we have legal responsibility to report this to the proper authorities. Such a report could potentially lead to disclosure of your being a client and require testimony concerning the suspected abuse.
- If, as part of an employment process or security screening, you sign a release of records form about services received from us, we will ask that you sign our form to ensure that you are freely and knowingly releasing a brief summary of your contact with us.
- We also reserve the right to consult with your primary care provider at the NMT Health Center when professionally appropriate.

Emergency Contact

By providing us with an emergency contact (next page) you have given us permission to contact this/these person(s) if an emergency arises in regards to your health safety.

I have read and understand the limits of confidentiality.

Client Signature _____ Date _____

Therapist Signature _____ Date _____

EMERGENCY CONTACTS:
Please call Campus Police – 575.835.5434 / 911
Socorro Mental Health – 575.835.2444
During normal business hours please call 575.835.6619

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CLIENT INFORMATION

Please fill out this form completely and bring to your first appointment. During your intake appointment, your therapist will discuss this information with you.

Date: _____

Banner ID#: **_____**

Name: _____ **Age:** _____ **DOB:** ____/____/____ **Gender:** □ Male □ Female
(Last) (First) (MI)

Marital Status: □ Never Married □ Partnered □ Married □ Separated □ Divorced □ Widowed
PO Box C/S #: _____ **Campus/Off Campus Address:**_____
Home Address: _____

Home Phone: (_____)_____ **May we leave a message?** □ YES □ NO

Cell Phone: (_____)_____ **May we leave a message?** □ YES □ NO

Email Address: _____ **May we email you?** □ YES □ NO
*please be aware email may not be confidential. *appointments and reminders are sent via email

Whom may we contact in case of emergency? _____
Address: _____ **Phone**:_____ **Relationship:**_____
Do we have your permission to speak with this person only in the event of an emergency? □ YES □ NO

LIVING SITUATION:
While at school I live: □ Alone □ with parents □ with roommates □ spouse/significant other □ other _____
How many roommates do you have? _____
How would you describe this relationship? _____
_____

How long have you lived in Socorro? _____

Where did you live prior to living in Socorro? _____

ENROLLMENT INFORMATION:
Are you a degree seeking student? □ YES □ NO

Year in School:
□ Freshman
□ Sophomore
□ Junior
□ Senior
□ Graduate

Student Status:
□ Full-time
□ Part-time
□ Other

DEMOGRAPHIC INFORMATION: ***(optional)***

Ethnicity:
□ American Indian/Native American
□ Asian
□ Bi-Ethnic
□ Black/African American
□ Hispanic/Latino
□ White/Anglo
□ Other (specify) _____

Gender Identity:
□ Male □ Female

Sexual Identity:
□ Bi-sexual
□ Gay
□ Lesbian
□ Straight/heterosexual

REFERRAL INFORMATION:
Who referred you to see us?
□ Self
□ Faculty/Advisor
□ Friend
□ Graduate Dean
□ Residence Halls
□ Student Health Center
□ Dean of Students
□ Other _____

PERSONAL INFORMATION
Do you have children? □ YES □ NO
Date of Birth: _____
Date of Birth: _____
Date of Birth: _____

EMPLOYMENT INFORMATION:
Are you employed? □ YES □ NO **Hours per week you work:** _____ **Do you work more than one job?** □ YES □ NO

Where do you work? _____
Are you attending your job on a regular basis? □ YES □ NO **If no, why**? _____

ACADEMIC INFORMATION:
Is this your first semester at NMT? □ YES □ NO
Date of first semester at Tech: _____ **Are you a transfer student?** □ YES □ NO
If yes where did you transfer from? _____
Have you been attending classes on a regular basis? □ YES □ NO
Has your academic performance changed in the last semester? □ YES □ NO, **If yes, how so and why?** _____
_____
_____
Are you on academic probation/suspension? □ YES □ NO **Are you on Financial Aid probation/suspension?** □ YES □ NO
Major area of study: _____ **Advisor:** _____
Current GPA? _____ **Amount of Credits Attempting**: _____

PHYSICAL HEALTH INFORMATION:
What is the status of your health? □ Excellent □ Good □ Fair □ Poor **Date of last physical**: _____
Do you have a primary care provider? □ YES □ NO **Allergies**: _____
If yes, what is his/her name and address? _____
Reason for medical care: _____
List any current/previous medications/supplements prescribed_____

I have tried to control my weight (in the past 12 months) with:
____ Diet pills ____ Excessive exercise ____ Not eating _____ Other _____
____ Diuretics ____ Laxatives ____ Vomiting
____ I have not tried to control my weight (in the past 12 months)

MENTAL HEALTH HISTORY:
Have you been a client of this office before? □ YES □ NO, If so when? _____
Have you been in therapy or counseling before? □ YES □ NO, If so when? And with whom? _____
_____
Did you receive a diagnosis? □ YES □ NO, Please describe:_____
_____
_____
Are you currently taking any medication? □ YES □ NO, If yes, please describe _____
_____
Have you been prescribed medication in the past? □ YES □ NO, If yes, please describe _____
_____
_____
Have you ever been hospitalized for a psychological problem? □ YES □ NO, Please describe (Please include dates)_____
_____
_____

I have specific thought/plans of killing myself:
___ Recently (in the last 5 – 7 days)
___ In the past _____In the past _____ Never
(less than a year ago) (more than a year ago)
____ At times I have acted in a violent manner.
____ I have been in trouble with the legal system.
____ My social/dating life is not satisfactory
____ There are sexual concerns I'd like to discuss.

I have specific thoughts/plan of killing others:
___ Recently (in the last 5 – 7 days)
___ In the past _____In the past _____ Never
(less than a year ago) (more then a year ago)
____ I am dissatisfied with my personal appearance.
____ Sometimes I hear strange voices in my head or see things that might not be real.
____ Sometimes I don't know where I am.

Do you feel like you are being abused or have been abused? □ YES □ NO Please describe: _____
_____
_____

PLEASE CHECK ALL OF THE FOLLOWING THAT APPLY
My family has a history of:
_____ Alcohol/drug abuse _____ Depression _____ Parents: Divorced/Separated _____ Family Suicide
_____ Attention Deficit Disorder _____ Eating Disorder _____ Physical/sexual abuse _____ Mental Health History
_____ Counseling/Therapy _____ Hospitalization _____ Poor communication

_____ My family is not emotionally close
_____ My relationship with my family is not satisfactory
_____ I cannot talk to my family about personal issues
_____ I am close to my family and have a good relationship with them

I AM EXPERIENCING PROBLEMS IN THE FOLLOWING AREAS: (Please check all that apply)

_____ Academic
_____ Childcare
_____ Conflict with roommate/friends
_____ Conflict with significant other(s)
_____ Expressing emotions
_____ Recent loss due: ___ death ___ relationship___ job termination
_____ Legal problems
_____ Managing anger
_____ Managing anxiety
_____ Financial Problems
_____ Unhappy with living arrangements
_____ Suicide
_____ Social isolation
_____ Sexual functioning

As a result of the stressors, I have problems with:

____ Anxiety/Panic Attacks
____ Appetite/Fatigue
____ Depression
____ Concentration
____ Headaches
____ Hallucinations
____ Mood shifts
____ Sleeping
____ Loss of Interest
____ Weight Loss/Gain
____ Energy/motivation
____ Avoidance
____ Relationships
____ School
____ Crying Spells

SUBSTANCE HISTORY

Have You Tried or Are Currently Using the Following (Check All That Apply)

	Alcohol	Tobacco	Heroin	Ecstasy	Methamphetamine	Methadone	Marijuana	Cocaine	Tranquilizers	Hallucinogens	Stimulants (Pills)	Rx Pain Killers
Occasionally												
Socially												
Weekly												
Daily												

Other drugs tried/currently using (please describe): _____
Have you ever been treated for drug/alcohol abuse? □ YES □ NO If yes, please provide dates: _____
For which substances: _____
Have you ever abused any kind of prescription medications? □ YES □ NO If yes, which ones: _____
Do you drink caffeinated beverages? □ YES □ NO If yes, how many per day: _____
Do you take any kind of substance to help keep you awake? □ YES □ NO If yes, please describe: _____
_____
I would like information on quitting smoking, using drugs, prescription medication or alcohol. □ YES □ NO

THE FOLLOWING HAVE RESULTED FROM MY ALCOHOL/DRUG USE (in the past 12 months)

____Academic problems
____ Blackouts
____ DWI
_____ Constant pain
____Fighting
____ Nothing significant
____ Ruined relationships
____ Traffic violations
____ NMT disciplinary action
____ Other (specify): _____

HEALTHY ALTERNATIVES (Check All That Apply)

	Exercise	Outdoor Activity	Walking	Drink Water	Eat Balanced Meals	Sleeping Well
Occasionally						
Sometimes						
Weekly						
Daily						
Never						

PLEASE DESCRIBE WHAT BRINGS YOU IN TODAY? (REQUIRED)

_____

_____

_____

_____

_____