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

Revised 09/2017
Office of Counseling & Disability Services

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

(List) (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? ___________________________ 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: DEMOGRAPHIC INFORMATION: (optional)

Are you a degree seeking student? □ YES □ NO

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

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

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: __________________________

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 your first semester at NMT? □ YES □ NO ___________________________________________
Date of first semester at Tech: __________________________ Is 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 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, whose 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 than 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

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My family is not emotionally close
I cannot talk to my family about personal issues
My relationship with my family is not satisfactory
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
- Legal problems
- Unhappy with living arrangements
- Childcare
- Managing anger
- Suicide
- Conflict with roommate/friends
- Managing anxiety
- Social isolation
- Conflict with significant other(s)
- Financial Problems
- Sexual functioning
- Expressing emotions
- Recent loss due: ___ death ___ relationship ___ job termination

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

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

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

<table>
<thead>
<tr>
<th>Alcohol</th>
<th>Tobacco</th>
<th>Heroin</th>
<th>Ecstasy</th>
<th>Methamphetamine</th>
<th>Methadone</th>
<th>Marijuana</th>
<th>Cocaine</th>
<th>Tranquilizers</th>
<th>Hallucinogens</th>
<th>Stimulants (Pills)</th>
<th>Rx Pain Killers</th>
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<td>Occasionally</td>
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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
- Fighting
- Traffic violations
- Blackouts
- Nothing significant
- NMT disciplinary action
- DWI
- Ruined relationships
- Other (specify):
- Constant pain

HEALTHY ALTERNATIVES (Check All That Apply)

<table>
<thead>
<tr>
<th>Exercise</th>
<th>Outdoor Activity</th>
<th>Walking</th>
<th>Drink Water</th>
<th>Eat Balanced Meals</th>
<th>Sleeping Well</th>
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<td>Occasionally</td>
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PLEASE DESCRIBE WHAT BRINGS YOU IN TODAY? (REQUIRED)

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