Client Intake Form

The following intake form is to be filled out by all new clients. You are welcome to print the paper version of this form and bring it with you to your intake appointment. The answers you provide will become part of your confidential mental health records. If you have any questions, feel free to discuss this form with your therapist.

DigiPen INSTITUTE OF TECHNOLOGY

Date of Request:

First Name: **Last Name:** **Student ID:**

Age: **Date of Birth:** **Ethnicity (optional):**

Gender Identity (optional): **Pronoun to be used in record:**

Current Major:

Class standing: ☐ Freshman ☐ Sophomore ☐ Junior ☐ Senior ☐ Master

Check if Applicable: ☐ Bilingual ☐ Disability ☐ International ☐ Transfer (Current academic year)

Address: **Apartment #:**

City: **State:** **Zip:**

Primary Phone: **Cell Phone:** **Email:** @digipen.edu

Emergency Contact (Name/Phone):

Have you had any previous mental health treatment? ☐ Yes ☐ No

If yes, please give details: when, where, how long, provider name, medication, etc.

Are you currently (or in the recent past) taking any prescription or over-the-counter medications? ☐ Yes ☐ No

If yes, please give details.

Does anyone in your family (blood relatives) have a mental illness? ☐ Yes ☐ No

If yes, please give details.

Do you drink alcohol? ☐ Yes ☐ No

If yes, please give details: how much, how often, any blackouts, etc.

Do you use any other recreational drugs? ☐ Yes ☐ No

If yes, please give details: how much, how often, last use, etc.

Have you ever had any type of eating disorder? ☐ Yes ☐ No

If yes, please give details:

Have you ever been charged with a crime, arrested or convicted? ☐ **Yes** ☐ **No**
If yes, please give details:

Do you have a history of trauma (any kind of abuse, neglect, victim of natural or other disaster, etc.)? ☐ **Yes** ☐ **No**
If yes, please give details:

SYMPTOMS CHECKLIST

Sleep: ☐ **No Problems** ☐ **Not enough** ☐ **Trouble getting up** ☐ **Nightmares** ☐ **Too much sleep**

Appetite: ☐ **No Problems** ☐ **No interest** ☐ **Increased appetite** ☐ **Carbohydrate craving**

Energy: ☐ **Normal** ☐ **Increased** ☐ **Low** ☐ **Up and down**

Interest in Sex: ☐ **Normal** ☐ **Increased** ☐ **Low**

Concentration: ☐ **Normal** ☐ **Somewhat difficult** ☐ **Poor** ☐ **Terrible**

Memory: ☐ **Good** ☐ **Some difficulty remembering** ☐ **Poor**

Depressed/sad: ☐ **All the time** ☐ **Most days** ☐ **Some days** ☐ **Not at all**

Suicidal thoughts: ☐ **All the time** ☐ **Most days** ☐ **Some days** ☐ **Not at all**

Past suicidal attempts: ☐ **No** ☐ **Yes**
If yes, please give details:

Anxiety: ☐ **Panic attacks** ☐ **All the time** ☐ **Most days** ☐ **Some days** ☐ **Not at all**

Anger/irritation: ☐ **All the time** ☐ **Most days** ☐ **Some days** ☐ **Not at all**

Please describe your reason(s) for coming to the Counseling Center:

Please contact us if you do not hear from a therapist in a reasonable time.

Local Phone: _____ May we leave a message here identifying ourselves from the Counseling Center? **Y / N**

Cell Phone: _____ May we leave a message here identifying ourselves from the Counseling Center? **Y / N**

How did you hear about us? _____

Who, if anyone has urged you to come here? _____

Have you been to counseling at DigiPen in the past? **YES / NO** If so, when? _____

Who, if anyone, has required you to come here? _____