

**Chadron State College  
Counseling Services**

**CONFIDENTIAL INTAKE QUESTIONNAIRE**

Please complete as fully as possible.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ E-mail: \_\_\_\_\_

Student I.D.: \_\_\_\_\_ Gender: \_\_\_\_\_

Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

What is your current classification?  Freshman  Sophomore  Junior  Senior

Major: \_\_\_\_\_ Minor: \_\_\_\_\_

Briefly state why you are seeking counseling. Please describe current symptoms, onset of symptoms, frequency, and duration of symptoms:

Have you ever received counseling services before?  Yes  No

If yes-

- Who did you see?
- How long were you in therapy?
- What was helpful? What was not helpful?

What are your goals for counseling?

**Psychiatric History:**

Have you ever experienced suicidal ideations?  Yes  No If yes, please explain.

Have you ever experienced homicidal ideations?  Yes  No If yes, please explain.

Have you ever attempted suicide?  Yes  No

If yes:

Number of attempts/methods? \_\_\_\_\_

Number of interrupted attempts? \_\_\_\_\_

Number of hospitalizations? \_\_\_\_\_

Have you ever engaged in non-suicidal self-injurious behavior?  Yes  No

If yes please explain:

Have you ever experienced seeing or hearing things that other people don't seem to notice?  Yes  No

If yes:

- When did you first notice this?
- How often does it happen?
- How distressing is it?

Have you ever felt like people were watching you, following you, or trying to harm you?

Yes  No

If yes, please explain:

Have you ever felt believed others were out to get you or plotting against you?

Yes  No

If yes, please explain:

Have you had significant weight loss or gain lately?  Yes  No

Please rate the following from 1-5 (1 strongly disagree, 2 disagree, 3 neutral, 4 agree, 5 strongly agree)

1. I feel comfortable in my body. 1 2 3 4 5
2. Thoughts about food or weight interfere with my daily life. 1 2 3 4 5
3. I feel guilt or shame related to eating. 1 2 3 4 5
4. I feel pressure to keep my body a certain way. 1 2 3 4 5

Do you have any concerns related to nutrition or physical health?  Yes  No

If yes, please explain:

Have/Do you ever use drugs, alcohol, nicotine, vapes, etc.?  Yes  No If yes, please list.

<u>Substance</u>	<u>Frequency of use</u>	<u>Age of first use</u>

Have you ever felt you ought to cut down on your drinking or drug use?  Yes  No

Have people annoyed you by criticizing your drinking or drug use?  Yes  No

Have you felt bad or guilty about your drinking or drug use?  Yes  No

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?  Yes  No

Has your use ever caused any personal injury, legal, or financial problems?  
If yes, please explain

**Family History**

1. Do you have any brothers or sisters?  Yes  No If yes, please list below.

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Name: \_\_\_\_\_ Age: \_\_\_\_\_  
 Name: \_\_\_\_\_ Age: \_\_\_\_\_ Name: \_\_\_\_\_ Age: \_\_\_\_\_  
 Name: \_\_\_\_\_ Age: \_\_\_\_\_ Name: \_\_\_\_\_ Age: \_\_\_\_\_

2. Describe your childhood in a few words.

3. Are your parents still married?

4. What is your relationship like with your parents?

5. Does/Did your father work?  Yes  No If yes, where? \_\_\_\_\_

6. Does/Did your mother work?  Yes  No If yes, where? \_\_\_\_\_

7. Did either of your parents abuse drugs or alcohol?  Yes  No  
If yes, how did it affect him/her?

8. Is there any family history of mental health diagnoses in your family? If so, please list:

**Developmental History**

Did you have any significant developmental problems in childhood or did you have an IEP/504 plan throughout school?

Yes  No If yes, please explain.

Was your mother’s pregnancy and delivery normal?  Yes  No

When did you achieve the major developmental milestones? If unsure, were they on time or delayed?

Have you ever had significant medical problems?  Yes  No If yes, please explain: (Please include any hospitalizations and/or surgeries)

Do you have any allergies or sensitivities?  Yes  No If yes, please explain:

**Trauma History**

Have you ever experienced any trauma?  Yes  No

If yes, please explain if you are comfortable:

**Social History**

Do you have any religious or spiritual preferences?  Yes  No If yes, please explain.

Have you ever served in the military?  Yes  No

If yes, what branch? \_\_\_\_\_ rank? \_\_\_\_\_

Dates of service: \_\_\_\_\_ type of discharge: \_\_\_\_\_

Did you serve in combat?  Yes  No

In addition to being a student, do you currently work?  Yes  No

Where? \_\_\_\_\_ For how long? \_\_\_\_\_

What are your responsibilities? \_\_\_\_\_

Do you enjoy your job?  Yes  No Why/Why not?

Do you have financial problems (i.e. difficulty managing debts)?  Yes  No If yes, please explain.

Are you or have you ever been married?  Yes  No

If no, are you involved in a long-term relationship?  Yes  No

If yes, what is your current marital status:

Married  Separated  Divorced  Widow/Widower

Do you have children?  Yes  No If yes, please complete section below:

Name	Age	Gender

Who would you consider your support system?

What do you enjoy doing in your leisure time (i.e. hobbies)?

Have you ever been involved in the legal system for criminal or civil charges?

Yes  No

If yes, please list.

**Date**

**Involvement**


Are you currently taking medication?  Yes  No If yes, please list.

Medication: \_\_\_\_\_ For what condition? \_\_\_\_\_

Medication: \_\_\_\_\_ For what condition? \_\_\_\_\_