

Please make sure you have discussed the **INFORMED CONSENT** with your client and it is signed by the client.



**Intake Form**

Electronic Case Record Number

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**University Counseling Center - Intake Form**

**Today’s Date** Click or tap to enter a date.

**Name: Click or tap here to enter text. Birth Date: Click or tap here to enter text.**

**Gender:  Male  Female Student ID: Click or tap here to enter text.**

**Cell Phone: Click or tap here to enter text. E-mail: Click or tap here to enter text.**

**Where do you live? Click or tap here to enter text.**

**Department of Study: Click or tap here to enter text. GPA: Click or tap here to enter text.**

**Preparatory  1st year  2nd year  3rd year  4th year  5th year  6th year**

**Who should be notified in case of emergency?**

1)Click or tap here to enter text. Click or tap here to enter text. Click or tap here to enter text.

(Name of the person) (Person’s relationship to you(e.g. father, friend)) (Phone number)

2) Click or tap here to enter text. Click or tap here to enter text. Click or tap here to enter text.

(Name of the person) (Person’s relationship to you(e.g. father, friend)) (Phone number)

***Did someone encourage you to come to counseling***?

Friend  Faculty  Academic Advisor  Campus Security  Dean of Student Affairs

Residence Staff  Student Services Staff  Made the decision to come yourself

***Have you received counseling before***?  Yes  No

If yes, please describe

Click or tap here to enter text.

What is your complaint that has brought you to counseling today?

**Academic**: Click or tap here to enter text.

**Social:** Click or tap here to enter text.

**Personal:** Click or tap here to enter text.

**Family:** Click or tap here to enter text.

**Other:** Click or tap here to enter text.

What do you wish to get out of counseling?

Click or tap here to enter text.

The answers you provide will be kept with the strictest of confidence, and it will be in your best interest to be to be totally honest. This info will be used to aid in helping you with your concern(s).

1. Have you or anyone else in your family ever been to counseling, received medical treatment for a mental, emotional, or psychological problem, or been tested for the same?

Click or tap here to enter text.

2. Are you currently taking any on-going medications? (if yes, please list the names)

Click or tap here to enter text.

3. What level of social/emotional support does your family provide?

None  Minimal  Some  A Lot

5. What level of social/emotional support does your friends provide?

None  Minimal  Some  A Lot

Check any of the following symptoms that apply to you:

poor appetite

depressed

loss of weight

lack of energy

anxious

nightmares

afraid

headaches

worried

impatient

shy

angry

eating a lot

guilt feelings

unmotivated  weight gain

feeling tired

always hungry

aggressive

seizures

suicidal thoughts

stomach trouble

Concentration issue

Difficulty making friends

trouble sleeping

Others (*Please Specify*): Click or tap here to enter text.

What are your hobbies? What do you like to do in your free time?

Click or tap here to enter text.

**Assessment: Lazarus-Basic ID**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| م | Cognitions – C | Always | Sometimes | Never |
| 1 | **I do not have the ability to remember well.** |  |  |  |
| 2 | **I have hard time concentrating while studying.** |  |  |  |
| 3 | **My ability to summarize the subject has become weak.** |  |  |  |
| 4 | **I am unable to absorb the subjects.** |  |  |  |
| 5 | **When I study I do not know where to start.** |  |  |  |
| Behavior- B | | Always | Sometimes | **N**ever |
| 1 | **I destroy the property of others.** |  |  |  |
| 2 | **I made quick decisions and then regret it.** |  |  |  |
| 3 | **I suffer from bouts of anger.** |  |  |  |
| 4 | **I am unable to organize my time.** |  |  |  |
| 5 | **I do not pay attention to**  **societal rules and norms.** |  |  |  |
| Affective- A | | Always | Sometimes | **N**ever |
| 1 | **I suffer from extreme tension during the exams.** |  |  |  |
| 2 | **I have a feeling of guilt.** |  |  |  |
| 3 | **I feel the desire to cry but I cannot.** |  |  |  |
| 4 | **I am afraid of social situations.** |  |  |  |
| 5 | **I feel sad without knowing why.** |  |  |  |
| Interpersonal Relationship –I | | Always | Sometimes | **N**ever |
| 1 | **I tend to isolate myself from others.** |  |  |  |
| 2 | **I have no desire to participate in social events.** |  |  |  |
| 3 | **I feel content with my old friends , and I am not looking for new friends.** |  |  |  |
| 4 | **I want to self-help without offering help others.** |  |  |  |
| 5 | **I have no desire to work in a team.** |  |  |  |
| Sensation- S | | Always | Sometimes | **N**ever |
| 1 | **I suffer from headaches.** |  |  |  |
| 2 | **I have irritable bowel pain.** |  |  |  |
| 3 | **I suffer from fatigue and**  **physical exhaustion.** |  |  |  |
| 4 | **My visual or auditory senses does not**  **help me to understand lectures.** |  |  |  |
| 5 | **I suffer from sleeping disorders.** |  |  |  |
| Images- I | | Always | Sometimes | **N**ever |
| 1 | **I hear strange noises when**  **I am on my own.** |  |  |  |
| 2 | **I often find myself daydreaming.** |  |  |  |
| 3 | **I feel sometimes that my**  **soul leaves my body.** |  |  |  |
| 4 | **I have a negative mental image**  **of what will happen to me in the future.** |  |  |  |
| 5 | **I have fantasies and thoughts**  **that are terrifying.** |  |  |  |
| Drugs- D | | Always | Sometimes | **N**ever |
| 1 | **I smoke daily.** |  |  |  |
| 2 | **I eat excessively.** |  |  |  |
| 3 | **I use drugs to feel happy.** |  |  |  |
| 4 | **I use drugs to increase my focus to study.** |  |  |  |
| 5 | **I do not practice any sports.** |  |  |  |

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**Results of Assessment (Lazarus Basic ID):**

Click or tap here to enter text.

**Summary of Initial Visit:**

Click or tap here to enter text.

**Notes**:

Click or tap here to enter text.

Counselor’s name: Click or tap here to enter text.