Total Health Center Counseling Center Initial Contact Form

We have developed this form to better meet your needs. All information will be kept confidential in a locked file cabinet at the THC. Please fill it out as best you can. If you can't, or choose not to, please leave it blank.

Name_____ Gender _____Referred by_____

Age_____ D.O.B._____ SS#_____

Home phone_____ Cell phone _____OK to call and identify ___yes ___no

Emergency Contact _____Phone number(s) _____

Please state as best you can why you decided to come for counseling/therapy (if unsure please state)

How long has this been a problem? (days, weeks, months, years)_____

What are your goals for counseling/therapy?

How would you describe the severity of this? Please circle.

Mild Moderate Serious Severe

What symptoms are related to this problem? Check all that apply.

_____eating issues ____depressed mood ____relationship problems

_____taking drugs ____crying ____increased alcohol use

_____social withdrawal ____ school problems ____suicidal ideation

_____sleep problems ____difficulty focusing ____increased anxiety

_____ compulsive behavior ____loss of energy ____other

If applicable, please describe any incidents or problems that may have triggered and/or been associated with this problem (e.g., academic problems, relationship ending, major life change, loss)

In the past what has been helpful to you in dealing with this problem

In the last two weeks, have you physically hurt yourself or someone else?

Have any members of your family had problems with

_____drugs_____ alcohol_____ depression____ anxiety_____ other mental health issues

Among your friends and family, whom do you count on for support?_____

Please list the amount that you use daily of the following caffeinated beverages
coffee_____soda_____espresso_____tea_____other_____

If applicable, number of cigarettes smoked per day_____

If applicable, in a typical week how much alcohol do you consume?_____

Do you binge drink? _____Have you experienced blackouts?_____ If yes how often?_____ If applicable, other substances used_____

Do you use alcohol or drugs to (check all that apply) manage stress___ relax _____change mood_____ socialize _____sleep_____

Anything else you'd like us to know?