Client Intake Form

The following intake form is to be filled out by all new and returning clients. 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 counselor.

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 ☐ Student with Disability ☐ International Student

Address: **Apartment #:**

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

Mobile Phone: **Email Address:** @digipen.edu

May we leave a message at this number identifying ourselves from the Counseling Center? ☐ Yes ☐ No

Emergency Contact (Name/Phone):

How did you hear about us?

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

Have you been diagnosed with any mental health condition? ☐ Yes ☐ No *If yes, please give details.*

Have you had any previous mental health treatment? ☐ Yes ☐ No
If yes, please give details: when, where, how long, provider name, medication, etc.

Have you received counseling services from DigiPen Counseling Center in the past? ☐ Yes ☐ No
If yes, please give details: which counselor, when, and how long, etc.

Do you have any chronic or temporary medical condition(s)? ☐ Yes ☐ No *If yes, please give details.*

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.*

Do you consume caffeinated beverages (coffee, tea, and caffeinated soda)? ☐ Yes ☐ No
If yes, please give details:

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	☐ Trouble falling asleep
	☐ Nightmares	☐ Too much sleep	☐ Waking up during sleep	How many times per night?
Appetite:	☐ No Problems	☐ No interest	☐ Increased appetite	☐ Carbohydrate craving
Energy Level:	☐ Normal	☐ Increased	☐ Low	☐ Up and down
Energy Drinks:	☐ Not at all	☐ 1 per day	☐ 2 per day	☐ 3+ per day
Interest in Sex:	☐ Normal	☐ Increased	☐ Low	
Focus:	☐ Good	☐ Poor	☐ Terrible	
Memory:	☐ Good	☐ Poor	☐ Terrible	
Anger/Irritation:	☐ Not at all	☐ Some days	☐ Most days	☐ All the time
Anxiety:	☐ Not at all	☐ Some days	☐ Most days	☐ All the time
Panic Attacks:	☐ Not at all	☐ Some days	☐ Most days	☐ All the time
Depressed/sad:	☐ Not at all	☐ Some days	☐ Most days	☐ All the time
Suicidal thoughts:	☐ Not at all	☐ Some days	☐ Most days	☐ All the time
Past suicidal attempts:	☐ No	☐ Yes		

If yes, please give details:

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

Please describe the change(s) you would like to make regarding your reason for coming to the Counseling Center: