

**Macalester College Counseling Services  
Intake Data Sheet**

Date: \_\_\_\_\_ Student's Name: \_\_\_\_\_ Student's ID: \_\_\_\_\_

Local Address: \_\_\_\_\_  
Residence Hall & Room Number or Local Street Address

Local Home Phone: \_\_\_\_\_ Local Work Phone: \_\_\_\_\_

Permanent Address: \_\_\_\_\_  
Street Address, City, State/Country

Permanent Phone: \_\_\_\_\_ Birth date: \_\_\_\_\_ Age: \_\_\_\_\_ Male Female  
(Circle one)

Year in School: FY So Jr Sr (Circle one) Academic Major: \_\_\_\_\_

**Academic Information:**

Please list the courses you are taking this semester:

- 1. \_\_\_\_\_ 4. \_\_\_\_\_
- 2. \_\_\_\_\_ 5. \_\_\_\_\_
- 3. \_\_\_\_\_ 6. \_\_\_\_\_

\* How would you describe your overall academic performance at Macalester? Excellent Good Fair Poor

\* Are you currently on academic probation or warning? Y N (Circle one)

\* Are you currently on social probation or warning? Y N

Have you attended any other colleges? Y N

If Yes, please list the college name, city, state, country, and year(s) of attendance:

\_\_\_\_\_  
\_\_\_\_\_

**Referral Information/Previous Counseling Experience:**

\* Were you referred to Counseling Services by anyone? Y N

If Yes, who? \_\_\_\_\_

\* Do you have any previous experience with counseling? Y N

If Yes, please list the approximate date(s), and issues discussed (optional): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\* **STEP 1: Check the concerns** you would like to explore with your counselor:

\* **STEP 2: For checked items only**, circle the degree to which the concern is currently problematic for you:

	<u>Mild</u>	<u>Moderate</u>	<u>Serious</u>	<u>Severe</u>
___ 1. Relationship difficulties: breakup/loss of relationship; problems with romantic partner, friends or roommates	1	2	3	4
___ 2. Family problems: divorce, separation, abuse; conflicts over money, roles, relationships or responsibilities	1	2	3	4
___ 3. Depression/moods: depressed mood, loss of interest or pleasure, hopelessness; alternating periods of elevated and depressed mood	1	2	3	4
___ 4. Suicidal thoughts or concerns: problems related to thoughts of suicide	1	2	3	4
___ 5. Anxiety: excessive or uncontrolled worry, nervousness, chronic fears, performance anxiety, panic attacks, social anxiety, obsessive thoughts, checking behaviors	1	2	3	4
___ 6. Stress or psychosomatic symptoms: overwhelmed by circumstances, problems with headaches, stomach pains, or sleep disturbances, etc.	1	2	3	4
___ 7. Anger management: concerns about managing anger, hostility, or frustration	1	2	3	4
___ 8. Academic difficulties: academic performance problems, missing classes	1	2	3	4
___ 9. College adjustment: problems adjusting to campus life, relationship between academics and future goals	1	2	3	4
___ 10. Cultural adjustment: difficulties adjusting or readjusting to North American social customs and mores	1	2	3	4
___ 11. Racial harassment: targeted by words or behaviors that interfere with full participation in community life	1	2	3	4
___ 12. Self-esteem: concern about self-image, shyness	1	2	3	4
___ 13. Death or loss: grief related to loss of a valued other	1	2	3	4
___ 14. Existential/spiritual concerns: search for meaning in life, concern about the role of religion in one's life	1	2	3	4
___ 15. Eating concerns and body image: purging, restricting, compulsive overeating, unhealthy dieting, excessive exercise, poor or inaccurate body image	1	2	3	4
___ 16. Alcohol and/or chemical use: concerns about abuse or developing dependency on alcohol or other drugs	1	2	3	4
___ 17. Self-inflicted harm: concerns about physical self-harm, i.e., cutting, burning, etc.	1	2	3	4
___ 18. Medication: concerns or questions about the appropriateness of medications	1	2	3	4
___ 19. Sexual abuse or harassment: rape, incest, harassment, being the subject of obsessive pursuit by another	1	2	3	4
___ 20. Sexual health: concerns related to sexual behavior	1	2	3	4
___ 21. Sexual identity: concerns or questions around sexual orientation	1	2	3	4
___ 22. Conduct violation: referred for violation of community conduct standards	1	2	3	4
___ 23. Other: _____	1	2	3	4

\* Please check the areas of your life that are affected by your current symptoms or problems:

- |  |   |
|--|---|
| <input type="checkbox"/> 1. Class performance/attendance | <input type="checkbox"/> 5. Family relationships  |
| <input type="checkbox"/> 2. Work performance/attendance  | <input type="checkbox"/> 6. Physical health       |
| <input type="checkbox"/> 3. Romantic relationships       | <input type="checkbox"/> 7. Spirituality/religion |
| <input type="checkbox"/> 4. Friendships/social life      | <input type="checkbox"/> 8. Other: _____          |

**Health/Medical History:**

How would you describe your overall physical health?    Excellent    Good    Fair    Poor    (Circle one)

Have you ever had any chronic health conditions, major illnesses, serious injuries, or significant head trauma?    Y    N

If Yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

\* Have you ever been hospitalized for psychological problems?    Y    N

If Yes, please describe what happened and give the date(s): \_\_\_\_\_  
\_\_\_\_\_

\* Have you ever attempted suicide?    Y    N

If Yes, please describe what happened and give the date(s): \_\_\_\_\_  
\_\_\_\_\_

Do you regularly take any medications, including over-the-counter medications?    Y    N

If Yes, please list the name(s) and dosage(s): \_\_\_\_\_  
\_\_\_\_\_

\* Are any of these medications for psychological difficulties?    Y    N

Is your medication being monitored by an M.D. or other health care professional?    Y    N

**Eating Concerns:**

Have you ever had concerns about your eating habits?    Y    N

Have friends, your doctor, parents, or anyone else ever told you they were concerned about your eating?    Y    N

\* Have you ever been treated for an eating disorder?    Y    N

If Yes, please describe the nature of the treatment and give the approximate date(s): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Family Background:** Please list the following information about your family members:

<u>Name</u>	<u>Age</u>	<u>Occupation</u>	<u>* Status:</u> (married, cohabitating, separated, divorced, remarried, deceased)
Parent			
Parent			
Stepmother			
Stepfather			
Siblings			

\* Please indicate any family history of the following: (Check all that apply)

- |                          |                              |                          |   |
|--------------------------|------------------------------|--------------------------|---|
| <input type="checkbox"/> | 1. Physical abuse            | <input type="checkbox"/> | 4. Depression, anxiety, or psychological difficulties |
| <input type="checkbox"/> | 2. Emotional or verbal abuse | <input type="checkbox"/> | 5. Medications for psychological difficulties         |
| <input type="checkbox"/> | 3. Sexual abuse or assault   | <input type="checkbox"/> | 6. Problems with alcohol or other drugs               |
|                          |                              | <input type="checkbox"/> | 7. None of the above                                  |

\* Please indicate if you personally have been the target of any of the following: (Check all that apply)

- |                          |                              |                          |                            |
|--------------------------|------------------------------|--------------------------|----------------------------|
| <input type="checkbox"/> | 1. Physical abuse            | <input type="checkbox"/> | 3. Sexual abuse or assault |
| <input type="checkbox"/> | 2. Emotional or verbal abuse | <input type="checkbox"/> | 4. None of the above       |

### **Race/Citizenship:**

What do you consider your racial or ethnic heritage to be? \_\_\_\_\_

Please indicate the country/countries of your citizenship: \_\_\_\_\_

### **Employment and Other Extracurricular Activities:**

\* Are you currently employed? Y N

If Yes, where? \_\_\_\_\_

How many hours/week do you work? \_\_\_\_\_

\* Are you currently involved in any volunteer activities, including internships (if not listed above)? Y N

If Yes, where? \_\_\_\_\_

How many hours/week are involved? \_\_\_\_\_

\* Are you currently involved in any regular sports activity, including varsity or intramural sports? Y N

If Yes, what sport? \_\_\_\_\_

How many hours/week are involved? \_\_\_\_\_

**Alcohol and Other Drug Use:**

\* Please check the box that best describes your current use of the following:

	<u>6 or More Times a Week</u>	<u>4-5 Times A Week</u>	<u>2-3 Times A Week</u>	<u>Once A Week</u>	<u>1-3 Times A Month</u>	<u>Once a Month or Less</u>	<u>Never</u>
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Marijuana	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(Other, please list)							
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(Other, please list)							

\* When you drink alcohol, how many drinks do you typically have? \_\_\_\_\_

Have you ever thought that you had a problem with alcohol or other drug use?    Y    N

\* If Yes, have you ever sought treatment?    Y    N  
Please describe the nature of the treatment and give the approximate date(s): \_\_\_\_\_

\_\_\_\_\_

**Goals for Counseling:**

Please list the goals you wish to achieve in counseling. Consider the way you would like to feel, problems you wish to solve, and coping skills you would like to learn:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Thank you for taking the time to complete this questionnaire. If you have any questions or concerns, please ask your counselor during your first visit.

## This Page For Office Use Only

**Date of Intake:** \_\_\_\_\_

**Counselor:**

Don DeBoer

Ashley Mercer

Mia Nosanow

Ted Rueff

Linda Schmid

**Services: (Check one only)**

Intake Interview:

\_\_\_\_\_ 1. Completed    \_\_\_\_\_ 2. Client cancel    \_\_\_\_\_ 3. No show    \_\_\_\_\_ 4. Office cancel

Scheduled Follow-up Appointment:

\_\_\_\_\_ 5. Completed    \_\_\_\_\_ 6. Client cancel    \_\_\_\_\_ 7. No show    \_\_\_\_\_ 8. Office cancel

Drop-In Appointment:

\_\_\_\_\_ 9. Intake interview    \_\_\_\_\_ 10. Follow-up session    \_\_\_\_\_ 11. Consultation

\_\_\_\_\_ 12. Other: \_\_\_\_\_

**Disposition: (Check all that apply)**

\_\_\_\_\_ 1. Return appointment scheduled for: **STNW** or \_\_\_\_\_

\_\_\_\_\_ 2. Referred to another counselor on staff

\_\_\_\_\_ 3. Returned to wait list

\_\_\_\_\_ 4. Referred to drop-in appointments as needed

\_\_\_\_\_ 5. Counseling ended

\_\_\_\_\_ 6. No show letter sent/phone call made

Off-campus referrals to:

\_\_\_\_\_ 1. Medication assessment/treatment

\_\_\_\_\_ 2. Personal counseling

\_\_\_\_\_ 3. Other physical/medical treatment

\_\_\_\_\_ 4. Chem. dep. assessment/treatment

\_\_\_\_\_ 5. Eating disorder assessment/treatment

\_\_\_\_\_ 6. Learning disability assessment

\_\_\_\_\_ 7. Other: \_\_\_\_\_

On-campus referrals to:

\_\_\_\_\_ 1. Academic Dean

\_\_\_\_\_ 2. Advisor or Faculty Member

\_\_\_\_\_ 3. Athletics Department

\_\_\_\_\_ 4. Career Development Center

\_\_\_\_\_ 5. Chaplain's Office

\_\_\_\_\_ 6. Dean of Students

\_\_\_\_\_ 7. Disability Services

\_\_\_\_\_ 8. International Center

\_\_\_\_\_ 9. Lealtad-Suzuki Center

\_\_\_\_\_ 10. Macalester Academic Excellence (MAX) Center

\_\_\_\_\_ 11. Medical Services (general medical)

\_\_\_\_\_ 12. Medication Assessment

\_\_\_\_\_ 13. Registrar/Bursar

\_\_\_\_\_ 14. Residential Life

\_\_\_\_\_ 15. Other: \_\_\_\_\_