WAKE TECH COMMUNITY COLLEGE

Wellness Services Intake Form

SECTION I: IDENTIFYING INFORMATION

Name: _____ **Today's Date:** _____

Address: _____ **City, State, Zip:** _____

Student ID#: _____ **Date of Birth:** _____ **Age:** _____

What do you prefer to be called? _____

Home phone: _____ **May we leave a message?** ☐ Yes ☐ No

Cell phone: _____ **May we leave a message?** ☐ Yes ☐ No

WTCC email: _____ **May we email you?** ☐ Yes ☐ No

Ethnic Background: ☐ African American ☐ Asian ☐ White ☐ Hispanic ☐ Native American
☐ International ☐ Multiracial ☐ Other: _____

Sexual Orientation: ☐ Heterosexual ☐ Lesbian ☐ Gay ☐ Bisexual
☐ Questioning
Other: _____ ☐ Prefer not to answer

Relationship Status: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
☐ Single ☐ Partnered ☐ Serious dating relationship

How were you referred to Wellness Services?

☐ Self ☐ Friend ☐ Behavioral Assessment Team ☐ Professional/Advisor/Staff

☐ Other: _____

Current/Prior Military Service: ☐ Yes ☐ No **Pending Court/Legal Issues:** ☐ Yes ☐ No

How many credit hours are you taking this semester? _____

☐ Full Time ☐ Part Time **Current GPA:** _____

Program of study: _____

Which campus are you near: _____

Are you currently employed? ☐ Yes ☐ No **Avg. # of hours worked weekly:** _____

Are you registered with Disability Support Services? ☐ Yes ☐ No

If yes, please indicate category: _____

SECTION II: CURRENT CONCERNS

Please give a brief statement of what is bringing you to counseling today:

Please check the following items that reflect your top <u>three</u> concerns:

- ☐ Academic problems
- ☐ Anxiety
- ☐ Adjustment to college/life changes
- ☐ Social problems (i.e. shy, lack of social contact)
- ☐ Grief/ loss
- ☐ Suicidal thoughts/plan/attempt
- ☐ Stress
- ☐ Depression
- ☐ Conflict in relationship
- ☐ Substance use (i.e. alcohol and other drugs)
- ☐ Auditory/visual hallucinations
- ☐ Homicidal thoughts/plan/attempt

Are you experiencing any of the following? Check all that apply:

- ☐ I am having thoughts of killing myself
- ☐ I am having thoughts of physically harming another person
- ☐ I cannot guarantee my own or other's safety if I leave campus
- ☐ I may be hearing or seeing things that I suspect are not real
- ☐ I believe that I or someone else is in danger
- ☐ I have experienced a recent assault or abuse
- ☐ I am not experiencing any of the above

Please check any of the following symptoms/problems you may have recently experienced:

☐ weight loss/gain	☐ fatigue	☐ panic attacks	☐ anger outbursts
☐ concentration	☐ low self-esteem	☐ mood shifts	☐ withdrawn/isolation
☐ sleep issues	☐ crying spells	☐ drug/substance use	☐ depression/sadness

***Please rate how your current concerns affect the following**:*

	Severely = 4	**Moderately = 3**	**Slightly = 2**	**Not at all = 1**
Ability to remain at WTCC				
Academic Performance				
Social Relationship				
Emotional Well-being				

SECTION III: MEDICAL HISTORY

Have you had prior counseling? ☐ Yes ☐ No

If yes, when?

What agency?

Have you had any prior hospitalizations for mental health or alcohol/substance use? ☐ Yes ☐ No

If yes, when?

What hospital?

Do you have any chronic health concerns? ☐ Yes ☐ No

If yes, please describe:

Are you currently taking medications? ☐ Yes ☐ No

If yes, please list medications and what they are prescribed for:

SECTION IV: EMERGENCY CONTACT

Emergency Contact (parent or close relative): _____

Relationship: _____

Emergency Contact Phone Number: _____

Signed: _____ Date: _____
(Student)

SECTION V: SUMMARY/NOTES (To be completed by the counselor.)

Signed: _____ Date: _____
(Counselor)