SUNY Broome Community College Counseling Intake Information and Consent

Date:_____

Name: _____
What name do you like to be called? :_____

B #:_____ Preferred Pronouns: _____

Date of Birth: ___/___/___
Gender ___ Female ___ Male ___Transgender ___ Gender Fluid ___ Bigender ___Agender
___Non-conforming ____ Pangender ___Other_____

Do you live on campus Yes/ No Do you live off campus YES/No

Current Address:_____

Email Address:_____

Cell Phone: _____/_____/_____ Home phone: _____/_____/_____
Is it ok to call you at home and or your cell and leave a message? ___Yes ____No
Is it ok to send you an email? ____Yes ___No

If no to both of the above, how would you like us to get in touch with you about your appointments?
_____
_____

Emergency Contact/Relationship to you: _____

Are you an International Student? ___Yes ____No

Are you currently in counseling in the community or anywhere else? ___Yes ___No
If yes, with who and where _____

Degree Program:_____ Do you know your career goal? ___Yes ___No
If so, What? _____
Are you or have you ever been on academic probation? ___Yes ___No ___Unsure

Did you transfer here from another college? ___Yes ___No What semester are you at Broome? _____

Are you planning on transferring to another college? ___Yes ___No ___Unsure Where?
_____

How many credits do you have completed:_____ ____ Unsure
Current **GPA**_____ ___ unsure

Broome Community College Counseling Intake Information

Name:

Relationship Status: Single /In Committed Relationship /Married /Divorced /Separated /Widowed

What brings you in? (choose all that apply, and circle your top three concerns)

Personal

- ☐Feeling depressed
- ☐Feeling stressed
- ☐Feeling worried/overwhelmed
- ☐Feeling overly sensitive
- ☐Trouble with anger
- ☐Self-esteem
- ☐Emotional numbness
- ☐Homesickness
- ☐Current or past abuse
- ☐Drug/alcohol use

Academic

- ☐Concerns about major
- ☐Concern about grades
- ☐Trouble keeping up in class
- ☐Trouble with professor

Work

- ☐Career focus
- ☐Trouble with finances
- ☐Employment issues

Relationships

- ☐Conflict with significant others
- ☐Trouble making/keeping friends
- ☐Trouble with family members
- ☐Sexual concerns
- ☐Loneliness
- ☐Grief/loss
- ☐Dating issues

Health

- ☐Eating concerns
- ☐Weight concerns
- ☐Disabilities
- ☐Dissatisfied with body
- ☐Trouble sleeping
- ☐Nightmares
- ☐Headaches/stomachaches

Personal Goals

- ☐Assertiveness
- ☐Communication
- ☐Stress management
- ☐Anger management
- ☐Clarifying own values
- ☐Getting to know myself
- ☐Getting to like myself
- ☐Boundaries
- ☐Keeping myself safe
- ☐Improving my relationships
- ☐Learning my limits
- ☐Not or cut use alcohol or drugs
- ☐Better physical/mental health

SUBSTANCE ABUSE/MENTAL HEALTH HISTORY

Do you use:

Alcohol

__ Yes __ Not currently but in the past

__ Never

Drugs

__ Yes __Not currently but in the past

__ Never

Have you been to counseling before?

__ Yes __ No

Have you ever been hospitalized for a mental health concern?

__ Yes __ No

Have you ever taken medication for a mental health concern?

__ Yes __ No

Have any of your family members had substance abuse issues?

__ Yes __ No

Have you ever received treatment for substance abuse?

__ Yes __ No

Have any of your family members had mental health issues?

__ Yes __ No

Are you concerned about your gambling, eating, sex, cleaning, shopping, internet, work, etc. habits?

__ Yes __ No (Circle one)

Have you ever thought of taking your own life? __ Yes __ No

In the last 6 months? __ Yes __ No

MEDICAL HISTORY

What is your doctor's name_____ ☐I don't have one
Date of last appointment: _____ For what?_____
Any past medical problems?_____
Medications: _____

PSYCHOSOCIAL INFORMATION

Mother's/Stepmother's name: _____
Occupation: _____
Father's/Stepfather's name: _____
Occupation: _____
Please list siblings name and ages:

If you are married and or have a family of your own:

Spouse/Partner/Significant Other Name: _____
If you have children, please list name and age below:

Other persons living in home:

Insurance: Do you have Insurance? __ Yes __ No

Disabilities: Do you have any disabilities? __ Yes __ No
If you answered yes, have you registered with the SUNY Broome's Learning Assistance Department? __ Yes __ No

Work: Do you work? __ Yes __No
If yes, where and how many hours: _____

Legal: Are you or have you been involved with the law? ___Yes ___No

Have you ever used any services at the Learning Assistance Department? ___Yes ___No

Who referred you to Counseling Services? _____

We sometimes offer group counseling and educational groups to students. Please put a check by any groups you might be interested in:
___ Smoking Cessation
___ Cognitive Behavioral Therapy Group for Social Anxiety
___ Mindfulness Meditation
___ Cognitive Behavioral Therapy Group for Depression

Are you interested in meeting with a career counselor or transfer counselor?
___Yes ___No

Recent changes in your life:

Anything else we should know/you want to tell us:

SUNY BROOME
Counseling Services
P.O. Box 1017 • Binghamton, New York 13902
Voice: (607) 778-5210 Fax: (607) 778-5204

Informed Consent for Treatment

My signature below indicates that I have read and received a copy of the SUNY Broome Community College's Counseling Services Informed Consent and agree to its contents, consenting to treatment:

_____ _____

Date Student's Signature

_____ _____

Date Counselor/other witness's Signature

IF CONSENTING PARTY IS OTHER THAN THE STUDENT:

I, _____, hereby consent to treatment for my minor child.

_____ _____

Date Signature of consenting party

_____

Relationship of consenting party

Release of information regarding status in counseling

PLEASE DO NOT SIGN UNTIL YOU MEET WITH A COUNSELOR:

In the event that my name should come before the Students of Concern Committee (SOC) or the Campus Assessment, Response and Evaluation Team (CARE), my signature below indicates that I agree to let my counselor disclose my status in counseling services. No other information will be shared without an additional release of information.

_____ _____

Date Student's Signature

_____ _____

Date Counselor's Signature