

Confidential Record

Informed Consent on File: _____

California State University Bakersfield
Counseling Center
9001 Stockdale Highway Bakersfield, CA 93311
(661) 664-3366

Date: _____

SSN#: _____

Counseling Intake

Name: _____ Date of Birth: _____

Address: _____
(Street-Apartment) (City) (State) (Zip Code)

Currently Enrolled? () Yes () No CSUB () or Extended University ()?

Major: _____ Class Level: _____ Units: _____ GPA: _____

Employer: _____

Phone(s): (H) () _____ (Pgr.) () _____ (W) () _____

Home/OK to leave message? ___ Yes ___ No Work/OK to leave message? ___ Yes ___ No

Relationship Status: _____ Single _____ In Relationship _____ Married/Partner
_____ Separated _____ Divorced _____ Widowed

Current Medical Problems: _____

Medication (s): _____

Prescribing Physician(s): _____

Date of Last Physical Exam: _____ Physician: _____

Previous Counseling? No ___ Yes ___ If yes, with whom? _____

Are you currently in counseling? No ___ Yes ___ If yes, with whom? _____

Brief description of the problem bringing you to counseling: _____

What is your counseling goal? _____

A checklist of symptoms and problems are listed below. Please check the areas that apply.

<u>History</u>	<u>Past</u>	<u>Present</u>	<u>History</u>	<u>Past</u>	<u>Present</u>
Depressed mood	()	()	Relationship problems	()	()

Anxious mood	()	()	Legal problems	()	()
Irritability	()	()	Alcohol abuse	()	()
Low esteem	()	()	Drug use	()	()
Impaired concentration	()	()	Sexual abuse	()	()
Eating problems	()	()	Suicide thoughts/attempt(s)	()	()
Elevated mood	()	()	Hospitalization	()	()
Sleeping problems	()	()	Self injury	()	()
Academic problems	()	()	Relationship violence	()	()