

**SUNY College at Fredonia  
Counseling Center – Confidential Intake Questionnaire**

Updated 8/12/08

Name: \_\_\_\_\_  
 Fredonia Address: \_\_\_\_\_  
 Local Phone: \_\_\_\_\_  
 Messages can be left at this number?  Yes  No  
 Contacts can be made over e-mail?  Yes  No  
 Email address: \_\_\_\_\_

Date: \_\_\_\_\_  
 Gender:  Male  Female  Other  
 Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_  
 Ethnicity: \_\_\_\_\_  
 Home Town: \_\_\_\_\_  
 Student ID# \_\_\_\_\_

**\*\*E-mail will only be used to address scheduling issues, as e-mail confidentiality cannot be guaranteed.**

**FAMILY INFORMATION**

Mother's Name: \_\_\_\_\_ Living?  Yes  No Occupation: \_\_\_\_\_ Age: \_\_\_\_  
 Father's Name: \_\_\_\_\_ Living?  Yes  No Occupation: \_\_\_\_\_ Age: \_\_\_\_

Parent's Marital Status:  Living Together  Separated  Divorced  Single

*List other members of your immediate family including step-parents and siblings, etc.*

Name	Relationship	Occupation	Age
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**ACADEMIC INFORMATION**

Major/Concentration: \_\_\_\_\_  
 Year in School: \_\_\_\_\_  
 Semester Hours: \_\_\_\_\_ GPA: \_\_\_\_\_  
 Transfer Student?  Yes  No  
 Non-academic Work (hrs/wk): \_\_\_\_\_  
 Type of Work: \_\_\_\_\_

**BACKGROUND INFORMATION**

Do you use tobacco-based products?  Yes  No  
 How much caffeine do you consume? \_\_\_\_\_  
 How often do you drink alcohol?  
 I don't drink  1-2 times/week  
 3-4 times/week  5 or more times/week  
 How many drinks per occasion?  
 1-3 drinks  4-8 drinks  8 or more drinks  
 Do you use other mood altering substances?  
 Yes  No *If yes, indicate the following:*  

Type	How Often?	Date of Last Use
<input type="checkbox"/> Stimulants	_____	_____
<input type="checkbox"/> Marijuana	_____	_____
<input type="checkbox"/> Cocaine	_____	_____
<input type="checkbox"/> Ecstasy	_____	_____
<input type="checkbox"/> Hallucinogens	_____	_____
<input type="checkbox"/> Heroin	_____	_____
<input type="checkbox"/> Others:	_____	

**PERSONAL INFORMATION**

Have you ever been seen at the SUNY Fredonia  
 Counseling Center before?  Yes  No  
 Have you received counseling/psychiatric  
 services from another provider?  Yes  No  
*If yes, please indicate the following:*  

Provider's Name	Dates Seen
_____	_____
_____	_____
_____	_____

Are you currently taking any medications  
 or herbal supplements?  Yes  No  
*If yes, please indicate the following:*  

Medication	Purpose	Dosage
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you had any serious illness, injuries, or allergies?  
 Yes  No *If yes, explain:*

Have you ever experienced memory loss as a result of  
 alcohol or substance use?  Yes  No  
 Have you ever been in trouble with the law or at school  
 due to alcohol or substance use?  Yes  No  
 Have you ever engaged in any of the following  
 behaviors? *Check all that apply:*  
 Binge Eating  
 Purging (vomiting to lose weight)  
 Excessive exercise to lose weight  
 Severely restricting food intake  
 Use of laxatives/diuretics to lose weight  
 Other eating/dieting behaviors that concern you  
 Has anyone ever told you that they were concerned about  
 your weight, dieting or eating habits?  Yes  No

## FAMILY HISTORY

Please indicate any family history of psychological problems (that you are aware of): *relationship/problems*

## CURRENT NEED

- What would you like to accomplish as a result of your participation in counseling?
  
- On a scale of “1 to 10”, with “10” being the situation at its worst and “1” being the day after it is resolved, circle where you are today? 0 1 2 3 4 5 6 7 8 9 10
  
- Would you be interested in attending a therapy or a support group  Yes  No
  
- Who referred/recommended that you come to the SUNY Fredonia Counseling Center?
  - Self  Friend  Professor/Advisor  Health Service  Residence Life Staff
  - Coach  Family Member  Judicial/Disciplinary Officer  Legal Counsel  University Police

**Please check all of the following that apply to you currently or in the past.**

Current Issue	Past Issue	
		Academic Problems
		Alcohol or Other Drug Use
		Anxiety, Nervousness, Worrying
		Career Issues
		Concern About Someone Else
		Conflict with Parents
		Conflict with Peers
		Depression
		Disability Issues
		Eating Problems/Eating Disorder
		Family Problems
		Fears, Phobias
		Feeling Out of Control
		Financial Concerns
		Gay/Lesbian/Bisexual Transgender Issues
		Health Issues, Allergies
		Identity Concerns
		Indecisiveness/Procrastination
		Irritability, Anger, Hostile Feelings

Current Issue	Past Issue	
		Legal Problems
		Loneliness, Homesickness
		Loss/Death of a Significant Person
		Perfectionism
		Pregnancy/Miscarriage/Abortion Issues
		Racial, Ethnic, or Cultural Issues
		Relationship Issues
		Religion/Spirituality Concerns
		Self-esteem, Self-confidence
		Self-injurious Behaviors
		Sexual Assault/Abuse
		Sexual Problems
		Shyness, Assertiveness Problems
		Sleep Difficulties, Nightmares
		Suicidal Feelings/Thoughts
		Troubling or Unusual Thoughts
		Thoughts of Being Violent to Others
		Victim of Violence or Abuse

The information provided on this form is an accurate representation of me: \_\_\_\_\_

Signature

Date