



**THE UNIVERSITY of
NEW MEXICO**

Student Health & Counseling (SHAC)
MSC06 3870
1 University of New Mexico
Albuquerque NM 87131-0001
(505) 277-4537 Fax: (505) 277-2020

-For Office Use Only-	
Rec'd date _____	Clin # _____ Code _____
Appt date _____	Time _____ Initials: _____
<input type="checkbox"/> Informed of WI, but refused	<input type="checkbox"/> WI _____
Triage: <input type="checkbox"/> Yes, ER <input type="checkbox"/> Yes <input type="checkbox"/> No	Triaged by: _____
Preferences: _____	Referred by: _____
Entered: <input type="checkbox"/> MM data <input type="checkbox"/> MM append <input type="checkbox"/> Triage	Initial: _____

Counseling Services Outpatient Intake Form

Name:	UNM ID#:	Birth date: / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Veteran <input type="checkbox"/> Yes <input type="checkbox"/> No
Local Address:	City:	State:	Zip:	
Email (*email is not confidential): <input type="checkbox"/> OK to contact me via email <input type="checkbox"/> Not OK	Home phone:	Cell phone:	Work phone:	

1. The problem I would like help with is:
2. Is this a life-threatening emergency that requires you to be seen now? <input type="checkbox"/> YES <input type="checkbox"/> NO
3. Is this a significant crisis that requires you to be seen today? <input type="checkbox"/> YES <input type="checkbox"/> NO

Current Mental Health Treatment <input type="checkbox"/> None	Previous Mental Health Treatment	Previous Mental Health Hospitalizations
MD or Psychiatrist:	Year _____	Year _____
Therapist:	<input type="checkbox"/> Here, Counseling Services <input type="checkbox"/> Lovelace <input type="checkbox"/> Presbyterian <input type="checkbox"/> Private Practitioner <input type="checkbox"/> UNM Mental Health Ctr <input type="checkbox"/> Other: _____	<input type="checkbox"/> Hospital: <input type="checkbox"/> Hospital: <input type="checkbox"/> _____

INSURANCE: <input type="checkbox"/> None <input type="checkbox"/> Student Health Insurance <input type="checkbox"/> Other:

Campus Attending:	Number of Credit Hours (if applicable):	GPA Cum:	GPA Current:	Major:
<input type="checkbox"/> Main/Albuquerque <input type="checkbox"/> Other:	Spring Summer Fall			

Relationship Status	While at school, I live:	Ethnic Origin	Referring Agency	University Status <i>(check all that apply)</i>
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Partnered <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Parent (____ # of children)	<input type="checkbox"/> Alone <input type="checkbox"/> With parents <input type="checkbox"/> With roommate(s) <input type="checkbox"/> Fraternity/Sorority <input type="checkbox"/> Spouse/Sign. Other <input type="checkbox"/> Other:	<input type="checkbox"/> American Indian <input type="checkbox"/> Anglo/Caucasian <input type="checkbox"/> Asian/Asian American <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic <input type="checkbox"/> International Student <input type="checkbox"/> Other:	<input type="checkbox"/> Self <input type="checkbox"/> Faculty/Advisor <input type="checkbox"/> Friend <input type="checkbox"/> Dean of Students <input type="checkbox"/> Residence Hall <input type="checkbox"/> Spouse/Partner <input type="checkbox"/> Other family member <input type="checkbox"/> Student Health Center <input type="checkbox"/> Other:	<input type="checkbox"/> Freshman <input type="checkbox"/> Sophomore <input type="checkbox"/> Junior <input type="checkbox"/> Senior <input type="checkbox"/> Graduate <input type="checkbox"/> Non-Degree <input type="checkbox"/> Academic Probation <input type="checkbox"/> Athlete, Specify sport:
Where did you live prior to living in Albuquerque?		How long have you lived in Albuquerque/metro Area?		

Emergency Contact:				
Name:	Relationship:	Home phone:	Work phone:	Cell phone:
Address, City, State, Zip				

***** PLEASE CONTINUE ON OTHER SIDE *****

**Please check any and all of the following that apply to you.
You may discuss these issues during the assessment interview.**

My family has a history of:

- | | | |
|--|---|---|
| <input type="checkbox"/> Alcohol/drug abuse | <input type="checkbox"/> Attention Deficit Disorder | <input type="checkbox"/> Counseling/Therapy |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Eating disorders | <input type="checkbox"/> Hospitalization |
| <input type="checkbox"/> Parents: Divorced/Separated | <input type="checkbox"/> Physical/sexual abuse | <input type="checkbox"/> Poor communication |
| <input type="checkbox"/> My family is not emotionally close. | <input type="checkbox"/> My relationship with my family is not satisfactory | |
| <input type="checkbox"/> I cannot talk to my family about personal issues. | | |

I am currently experiencing stress in the following areas:

- | | | |
|---|--|---|
| <input type="checkbox"/> Academic | <input type="checkbox"/> Expressing emotions | <input type="checkbox"/> Legal problems |
| <input type="checkbox"/> Childcare | <input type="checkbox"/> Financial | <input type="checkbox"/> Managing anger |
| <input type="checkbox"/> Conflict with roommate/friends | <input type="checkbox"/> Sexual functioning | <input type="checkbox"/> Managing anxiety |
| <input type="checkbox"/> Conflict with significant other(s) | <input type="checkbox"/> Social isolation | <input type="checkbox"/> Unhappy with living arrangements |
| <input type="checkbox"/> Recent loss due to: ___ death ___ relationship ___ job termination | | |

As a result of the stressors, I have problems with:

- | | | |
|--|--------------------------------------|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Headaches | <input type="checkbox"/> Weight Loss/Gain |
| <input type="checkbox"/> Appetite | <input type="checkbox"/> Mood shifts | <input type="checkbox"/> Energy/motivation |
| <input type="checkbox"/> Concentration | <input type="checkbox"/> Sleeping | <input type="checkbox"/> Violence |

The following have resulted from alcohol/drug use (in the past 12 months):

- | | | |
|---|---|--|
| <input type="checkbox"/> Academic problems | <input type="checkbox"/> Fighting | <input type="checkbox"/> DWI |
| <input type="checkbox"/> Blackouts | <input type="checkbox"/> Nothing significant | <input type="checkbox"/> UNM disciplinary action |
| <input type="checkbox"/> Traffic violations | <input type="checkbox"/> Ruined relationships | <input type="checkbox"/> Employment issues |
| <input type="checkbox"/> Sexual problems | <input type="checkbox"/> Health problems | <input type="checkbox"/> Other (specify): |

I have tried to control my weight (in the past 12 months) with:

- | | | |
|---|---|-------------------------------------|
| <input type="checkbox"/> Diet pills | <input type="checkbox"/> Excessive exercise | <input type="checkbox"/> Not eating |
| <input type="checkbox"/> Diuretics | <input type="checkbox"/> Laxatives | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Healthy Diet and/or Exercise | <input type="checkbox"/> Other: | |
| <input type="checkbox"/> I have not tried to control my weight (in the past 12 months). | | |

I have specific thoughts/plans of killing myself:

- | | | | |
|--------------------------------|--|---|---|
| <input type="checkbox"/> Never | <input type="checkbox"/> Recently (in the last 5-7 days) | <input type="checkbox"/> In the past (less than a year ago) | <input type="checkbox"/> In the past (more than a year ago) |
|--------------------------------|--|---|---|

I have made an attempt:

- | | | | |
|--------------------------------|--|---|---|
| <input type="checkbox"/> Never | <input type="checkbox"/> Recently (in the last 5-7 days) | <input type="checkbox"/> In the past (less than a year ago) | <input type="checkbox"/> In the past (more than a year ago) |
|--------------------------------|--|---|---|

I have specific thoughts/plans of killing others:

- | | | | |
|--------------------------------|--|---|---|
| <input type="checkbox"/> Never | <input type="checkbox"/> Recently (in the last 5-7 days) | <input type="checkbox"/> In the past (less than a year ago) | <input type="checkbox"/> In the past (more than a year ago) |
|--------------------------------|--|---|---|

I have made an attempt:

- | | | | |
|--------------------------------|--|---|---|
| <input type="checkbox"/> Never | <input type="checkbox"/> Recently (in the last 5-7 days) | <input type="checkbox"/> In the past (less than a year ago) | <input type="checkbox"/> In the past (more than a year ago) |
|--------------------------------|--|---|---|

Check all that apply:

- | | |
|---|---|
| <input type="checkbox"/> At times I have acted in a violent manner. | <input type="checkbox"/> I am dissatisfied with my personal appearance. |
| <input type="checkbox"/> I have been in trouble with the legal system. | <input type="checkbox"/> Sometimes I hear strange voices in my head or see things that might not be real. |
| <input type="checkbox"/> My social/dating life is not satisfactory. | <input type="checkbox"/> Sometimes I do not know where I am. |
| <input type="checkbox"/> There are sexual concerns I'd like to discuss. | |

Signature:

Date: