PERSONAL COUNSELING
STUDENT INTEREST FORM

Today's Date: _____ **Student ID #:** _____

Name: _____

Mobile Phone#: _____ **CAN I LEAVE A MESSAGE?** **YES** ☐ **NO** ☐

Home Phone #: _____ **CAN I LEAVE A MESSAGE?** **YES** ☐ **NO** ☐

E-mail Address: _____ **CAN I LEAVE A MESSAGE?** **YES** ☐ **NO** ☐

Emergency Contact Name: _____

Relationship to Emergency Contact: _____ **Phone #:** _____

Date of Birth: _____ **Age:** _____ **Language Preference:** _____

Gender Identity (Female/Male/Transgender/None/Other): _____

Preferred Pronouns: _____ **Race/Ethnicity:** _____

How did you hear about us? _____

Counselor Preference (if any): _____

Are you a student enrolled in at least one unit at Cuyamaca College? **YES** ☐ **NO** ☐

Are you *currently* having thoughts about hurting, harming, or ending your life? **YES** ☐ **NO** ☐

Are you having thoughts of hurting or harming others? **YES** ☐ **NO** ☐

Please circle a time block for days that you are available:

TUESDAY: (9:00 AM - 12:00 PM) (12:00 PM – 3:00 PM)

THURSDAY: (9:00 AM – 12:00 PM) (2:00 PM – 5:00 PM)

FRIDAY: (9:00 AM- 12:00 PM) (12:00 PM – 3:00 PM)

Have you ever been in counseling before? Reasons for seeking counseling today. Other Comments.

_____

_____

_____

_____

Over the last *2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	
TOTAL:				

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

OFFICE USE ONLY: CONTACT HISTORY

1st Attempt: Date _____ Initials: _____ Note: _____

2nd Attempt: Date _____ Initials: _____ Note: _____

Final Status: Open ☐ Date _____ Counselor: _____ Inactive ☐ (never opened)