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.

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

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)