Juniata College
Health & Wellness Counseling Center
INITIAL ASSESSMENT

DATE________________________

Name____________________________________

Date of Birth _______________ **Age** __________ **Class Year** ___________

Email _____________________________ **Cell** ____________________ **Hometown/State**________________________

Emergency Contact ______________________________ **Emergency Number** _________________________________

Gender Identity________________________ **Race/Ethnicity** ______________________________________

Referral Source
☐Self ☐Parent(s) ☐Dean ☐RA/RD/RLC ☐Friend ☐Other__________________

Residence ________________________________ **Roommate(s)** ____________________________________

____

Education / Military
Program of Emphasis ___________________________ Grades _________________________

Barriers to learning ____

☐International Student………….. Country ______________________

☐Transfer Student………………… From _____________________________________

☐Military Experience…………… Describe ____

Work
☐On-Campus (Identify) ______________________Hours ☐1-5 ☐6-10 ☐11-15 ☐16-20 ☐21-30 ☐31+
☐Off-Campus (Identify) ______________________Hours ☐1-5 ☐6-10 ☐11-15 ☐16-20 ☐21-30 ☐31+

Extra-Curricular Activities / Clubs

Sexual Orientation
☐Heterosexual ☐Bisexual ☐Lesbian/Gay ☐Queer
☐Questioning ☐Asexual ☐Other ________________ ☐Decline to answer

Relationship Status
☐Single ☐Recent Break-up ☐Significant Other ☐Married/Partnered ☐Other_______________
Length of time ____________________
☐Children ____

Social Supports

☐Family ☐Friends ☐Athletics team ☐Religious Activities ☐Other (describe below)

Comments:____

____

Presenting Problem Today:____

____

____

Please CHECK ITEMS THAT APPLY. Check only those which apply to your presenting concern(s):

___ Academic concerns
___ Addiction
___ ADHD/learning problem
___ Adjustment to college
___ Adjustment to new situations
___ Alcohol or drug concerns
___ Anger management
___ Anxiety, fear, nervousness
___ Career/job concerns
___ Compulsive Behavior
___ Concentration difficulties
___ Concern with other's well-being
___ Cultural/multicultural concerns
___ Cutting or self injury
___ Depression, sadness
___ Discrimination
___ Eating concerns/body image
___ Emotional or Psychological abuse
___ Episodes of manic behavior
___ Faculty/advisor concerns
___ Family problems
___ Feeling doomed or helpless
___ Financial concerns
___ Graduation preoccupations
___ Harassment
___ Identity/sense of self
___ Impulse control
___ Internet/videogame concerns
___ Intimate relationship concerns
___ Interpersonal concerns
___ Legal concerns
___ Loneliness
___ Loss, grief, death
___ Self-esteem
___ Medical or health concerns
___ Obsessive thoughts
___ Panic Attacks
___ Paranoia
___ Phobias
___ Physical abuse or assault
___ Procrastination
___ Re-entry concerns
___ Relationship concerns
___ Sexual abuse or sexual assault
___ Sexuality concerns
___ Sleep difficulties
___ Spiritual or religious concerns
___ Stress or tension
___ Suicidal thoughts
___ Racing thoughts
___ Trouble making decisions
___ Other presenting concern (specify)

____

Of these concerns, which 3 are the most important right now?

1.____

2.____

3.____

So far, what solutions to your problems have been most helpful? ____

____

How much do your concerns interfere with your (please circle):

Academic Performance :						
Not much	1	2	3	4	5	Greatly
Emotional Well-being:						
Not much	1	2	3	4	5	Greatly
Social Relationships/Social Activities:						
Not much	1	2	3	4	5	Greatly
Daily Routine:						
Not much	1	2	3	4	5	Greatly

Due to the impact of your concerns on your Academic Performance, are you considering:

_____Withdrawing for the semester

_____Not enrolling next semester

_____Dropping Out Transferring

_____Other: (specify)__________________________

____

_____Not Applicable

MENTAL HEALTH HISTORY

Have you received counseling or psychotherapy before?
____No ____Before high school ____High school ____Before attending college

Are you a returning client to Juniata College Health & Wellness Center Counseling? ____Yes _____No

If YES, when did you receive services here, and who was the mental health provider/counselor: ___________________________________

Are you currently receiving psychiatric services, counseling, or psychotherapy elsewhere? ____Yes ____ No

If YES, please provide the mental health provider's name and phone number: ____

Have you been prescribed psychiatric medication in the PAST? ____Yes (specify below) ____No

Please list what medications, dosage, and when taken: ____

____

Are you CURRENTLY taking prescribed psychiatric medication, antidepressants, or others? ____Yes (specify) ____ No

If YES, please list any psychiatric medications you are CURRENTLY taking and the prescribing doctor: _____________________________

____

Are the medications helpful? ____Yes ____No

Have you been hospitalized for psychiatric reasons? ____Yes (specify below) ____No
If YES, please specify reason for past hospitalization: (check all that apply):
____Psychological problems _____Suicide ideation/attempt ____Danger to others ______Drug/alcohol
_______Other

When and where you were hospitalized:____

If you marked OTHER above, also describe the reason for your hospitalization:____

Was the hospitalization helpful? __________Yes ___________No

Have you ever had thoughts of harming yourself? ______Yes _____ No

Have you purposely injured yourself without suicidal intent? (cutting, hitting, burning, etc.) ____ Yes (specify) _____No
If yes, when did this occur:
____in the past, but stopped
____in the past, but currently going on
____recently

In the last few days, have you had suicidal thoughts? ____ Yes (specify below) ____ No
If YES, please circle the correct response:

FREQUENCY: Rarely Sometimes Frequently Always

DURATION: Seconds Minutes Hours Constant

INTENSITY: Brief and fleeting Focused deliberation Intense rumination

Have you seriously considered attempting suicide in the past? ____ Yes (specify below) ____ No

If YES, please describe: (how old were you, issues/problems, what happened)____

____

Have you ever made a suicide attempt? ____Yes (specify below) ____No

If YES, please describe when and the nature of the attempt: ____

____

Did you receive help? ____Yes (specify below) ____ No
If YES, please describe when and the nature of the help you received: ____

____

Have you seriously considered harming another person? ____ Yes (specify below) ____ No

If YES, describe when, who, and how: ____

____

Have you ever intentionally physically harmed someone? ____Yes (specify below) ____ No

If YES, describe when, who, and how: ____

____

Do you CURRENTLY have thoughts of harming another person? ____Yes (specify below) ____ No

If YES, please describe: ____

____

DRUG AND ALCOHOL HISTORY

Do you regularly use alcohol? ____ Yes ____ No

In a typical month, how often do you have 4 OR MORE DRINKS in a 24-hour period?
Never Rarely Monthly Weekly Daily or Almost Daily

Do you consider your alcohol consumption a problem? ____Yes ____ No ____ Not Applicable

Have you used ANY drug in the past 30 days that was NOT prescribed by a doctor? (marijuana, meth, cocaine, diet pills, ecstasy, Xanax, valium, Ritalin, Adderall, LSD, acid, mushrooms, heroin, codeine, other)

____Yes (specify below) ____No

If YES, indicate which substance(s) and when: ____

____

How often do you engage in recreational drug use? Never Rarely Monthly Weekly Daily/Almost Daily

Do you consider your drug use a problem? ____ Yes ____ No ____ Not Applicable

Have you ever received treatment for alcohol or drug use? ____ Yes (specify below) _____ No

If YES, indicate when, where, and for what substance(s) ____

____

Was it helpful? ____ Yes ____ No

What is your typical DAILY CAFFEINE intake?

Never/rarely 12-24oz (1-2 cups/servings) 25-60oz (3-5 cups/servings) More than 60oz (5+ cups/servings)

What is your typical DAILY NICOTINE intake?

Never/rarely Less than 5 cigarettes 5-20 cigarettes More than 20 cigarettes Other (e.g., nicotine patch)

SLEEPING & EATING HABITS

Are you having any problem with your sleep habits?

No problems Sleeping too much Sleeping too little Poor quality of sleep Disturbing dreams

Other (please describe)____

Are you having difficulty with appetite or eating habits?

No difficulty Eating less Eating more Binging Restricting Significant weight change

Other (specify)____

Please describe the nature of your eating habits or weight change: ______________________________________

____

MISCELLANEOUS

How many times per week do you EXERCISE? One or less Two to Four Five or more

Approximately how long each time? ____

Do you have any problems or worries about SEXUAL FUNCTIONING? (circle all that apply)

No concerns Lack of desire Performance problem Sexual impulsiveness Difficulty maintaining arousal

Did you experience LEARNING PROBLEMS in elementary or high school?

None A little Some Substantial A lot, constant struggle

Are you receiving services from Juniata College Academic Support Services? ____No _____Yes When did you start?_____________

Have you personally experienced LEGAL PROBLEMS? _____Yes _____No

If YES, please describe: ____

Please list any PERSISTENT PHYSICAL SYMPTOMS or health concerns: (e.g., chronic pain, headaches, hypertension, diabetes, etc.)

____

____

RELATIONSHIPS

Approximately how many significant intimate relationships (lasting 6 months or more) have you been involved in the last couple of years?

____

In general, how happy were you growing up?

Not at all   Unsatisfactory   Average   Substantially   Completely

Does your family speak a language other than English at home?   No   Very little   Sometimes   Moderately   Strongly

If YES, what language(s): ____

What is your ethnic identity? ___________________________________

How much do you identify with your ethnic heritage?   Not at all   A little   Somewhat   Moderately   Strongly

How much conflict in values do you currently experience with your parents?

Very little or none   Some   Moderate   Strong   Extreme

Religious preference: Are you currently active in your religion?   ___Yes   ____No

How much is your immediate family a source of emotional support for you?

Not at all   A little   Somewhat   Substantial   Very strong

Please check any past, present, or impending special problems in your family. Please specify the problem, family member(s), and time of occurrence:

____ DIVORCE/MARITAL PROBLEMS ____

____ SERIOUS PHYSICAL ILLNESS, DISABILITY, OR DEATH ____________________________

____ ALCOHOL/SUBSTANCE ABUSE PROBLEMS_________________________________

____ PSYCHIATRIC ILLNESS/EMOTIONAL PROBLEMS ___________________________

____ FINANCIAL PROBLEMS/UNEMPLOYMENT_________________________________

____ LEGAL PROBLEMS____

____ OTHER____