



## STUDENT RE-INTAKE INFORMATION - CONTINUED

<b>H E A L T H  I N F O R M A T I O N</b>	<p><b>Please list any professional health care providers you are currently seeing:</b> <i>Please list: Physicians, Psychiatrists, Counselors and Therapists</i></p> <hr/> <hr/>
	<p><b>Please list any professional health care providers you have seen in the past:</b> <i>Please list names &amp; dates of service from: Physicians, Psychiatrists, Counselors and Therapists.</i></p> <hr/> <hr/>
	<p><b>Have you been hospitalized for a mental health reason? (where/when)</b></p> <hr/>
	<p><b>Are you currently taking any medication?</b>   <input type="checkbox"/> No   <input type="checkbox"/> Yes, <i>Please List:</i></p> <hr/>
	<p><b>Have you previously taken any medication for mental health reasons? (i.e. depression/anxiety)</b> <input type="checkbox"/> No   <input type="checkbox"/> Yes, <i>Please List:</i> _____</p> <hr/>
	<p><b>Have any family members been diagnosed/treated for mental health or substance abuse reasons?</b> <input type="checkbox"/> No   <input type="checkbox"/> Yes, <i>Please Explain:</i> _____</p> <hr/>

<b>F A M I L Y</b>	<b>Please identify the members of your immediate family:</b>							
			Name	Occupation	Age	Deceased	Divorced	Remarried
	Mother					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Father					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Stepmother					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Stepfather					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Sibling					<input type="checkbox"/> Yes <input type="checkbox"/> No		
	Sibling					<input type="checkbox"/> Yes <input type="checkbox"/> No		
						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Were you adopted?</b> <input type="checkbox"/> N/A <input type="checkbox"/> Yes, If Yes, at what age? _____								

<b>C O N C E R N S</b>	<p>Please state briefly your current concerns that you are seeking our services for:</p> <hr/> <hr/>
	<p>How long has this been a concern? (days/weeks/months/years): _____</p>
	<p><b>Is this concern life threatening?</b>   <input type="checkbox"/> No   <input type="checkbox"/> Yes</p>
	<p>How would you estimate the severity of the problem? (<i>Place an X on the line below</i>)</p> <hr/>
	<p><i>Mild</i> <span style="margin-left: 200px;"><i>Moderate</i></span> <span style="float: right;"><i>Severe</i></span></p>
	<p><b>Are you experiencing suicidal feelings or thoughts</b>   <input type="checkbox"/> No   <input type="checkbox"/> Yes</p>
	<p><b>Are you experiencing homicidal feelings or thoughts</b>   <input type="checkbox"/> No   <input type="checkbox"/> Yes</p>
	<p>Are you currently involved in a legal investigation   <input type="checkbox"/> No   <input type="checkbox"/> Yes</p> <p>Are you currently involved in a Student Rights and Responsibilities case   <input type="checkbox"/> No   <input type="checkbox"/> Yes</p> <p>Are your concerns negatively impacting your academic situation   <input type="checkbox"/> No   <input type="checkbox"/> Yes</p>



## Counseling Center

Anderson University Center 300, Tacoma, WA 98447

Phone: 253-535-7206, Fax: 253-536-5124

# CONFIDENTIAL

CCAPS-34

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**INSTRUCTIONS:** The following statements describe thoughts, feelings, and experiences that people may have. Please indicate how well each statement describes you, during the past two weeks, from "not at all like me" (0) to "extremely like me" (4), by marking the correct number. Read each statement carefully, select only one answer per statement, and please do not skip any questions.

	Not at all like me	-----			Extremely like me
	①	①	②	③	④
1. I am shy around others	①	①	②	③	④
2. My heart races for no good reason	①	①	②	③	④
3. I feel out of control when I eat	①	①	②	③	④
4. I don't enjoy being around people as much as I used to	①	①	②	③	④
5. I feel isolated and alone	①	①	②	③	④
6. I think about food more than I would like to	①	①	②	③	④
7. I am anxious that I might have a panic attack in public	①	①	②	③	④
8. I feel confident that I can succeed academically	①	①	②	③	④
9. I have sleep difficulties	①	①	②	③	④
10. My thoughts are racing	①	①	②	③	④
11. I feel worthless	①	①	②	③	④
12. I feel helpless	①	①	②	③	④
13. I eat too much	①	①	②	③	④
14. I drink alcohol frequently	①	①	②	③	④
15. I have spells of terror or panic	①	①	②	③	④
16. When I drink alcohol I can't remember what happened	①	①	②	③	④
17. I feel tense	①	①	②	③	④
18. I have difficulty controlling my temper	①	①	②	③	④
19. I make friends easily	①	①	②	③	④
20. I sometimes feel like smashing or breaking things	①	①	②	③	④
21. I feel sad all the time	①	①	②	③	④
22. I am concerned that other people do not like me	①	①	②	③	④
23. I get angry easily	①	①	②	③	④
24. I feel uncomfortable around people I don't know	①	①	②	③	④
25. I have thoughts of ending my life	①	①	②	③	④
26. I feel self conscious around others	①	①	②	③	④
27. I drink more than I should	①	①	②	③	④
28. I am not able to concentrate as well as usual	①	①	②	③	④
29. I am afraid I may lose control and act violently	①	①	②	③	④
30. It's hard to stay motivated for my classes	①	①	②	③	④
31. I have done something I have regretted because of drinking	①	①	②	③	④
32. I frequently get into arguments	①	①	②	③	④
33. I am unable to keep up with my schoolwork	①	①	②	③	④
34. I have thoughts of hurting others	①	①	②	③	④



Name \_\_\_\_\_ PLU ID # \_\_\_\_\_ Date \_\_\_\_\_

Describe special interests, hobbies, or activities that you enjoy and that you have been avoiding as a result of what you have been struggling with:

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What are the three things that you value the most in your life right now?

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What change(s) would have to happen in order for you to move forward in your life? Do you believe this is possible?

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FOR OFFICE USE ONLY:  
CLINICAL IMPRESSIONS & CONSIDERATIONS:

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DISPOSITION:

- Placed in Springboard Workshop
- Placed conjointly in Springboard workshops and individual counseling (If so, explain why)

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- Referred out/off campus
- Placed immediately in individual counseling
- Will not complete springboard (If so, explain why)

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- C-CAPS Responses: #25 \_\_\_\_\_, #29 \_\_\_\_\_, #34 \_\_\_\_\_

Counselor Signature: \_\_\_\_\_ Date: \_\_\_\_\_