Name: _____ Preferred Name/Pronouns: _____ Student ID#: _____

Phone #: _____ Current LOCAL Address: _____

Please ✓ ALL that apply:

1. **_____ I am having thoughts of hurting or killing myself or someone else.**
2. **_____ I have a current plan to attempt suicide or physically hurt someone else.**
3. **_____ I am hearing voices and/or seeing things that others do not.**
4. **_____ I am in distress and unable to care for my basic needs. (sleeping, going to class/work, eating, hygiene, etc.)**
5. **_____ I have recently experienced the death of a loved one or another significant loss.**
6. _____ I have recently experienced a physical or sexual assault/abuse or other form of violence/abuse. (CVRC)
7. _____ I'm interested in scheduling a phone screening for another day to determine services to meet my needs
8. _____ Other (please explain):

   _____

9. **__*I was referred by my primary care provider in the Student Health Service (Level 1, SHS)***

Options that may be discussed/recommended during your screening for services include the following. Please check options you would like to discuss (✓ all that apply).

☐ I'm interested in or open to attending group counseling.

☐ I'm looking for workshops that I can attend.

☐ I have a concern that I believe can be addressed in one meeting today.

☐ I'm interested in looking at/changing my alcohol/drug use.

☐ I'm interested in building my coping skills.

☐ I'm interested in starting medication.

☐ I'm interested in short-term individual counseling.

☐ I'm interested in medication and/or testing for ADHD.

☐ I have concerns about someone else.

☐ I **would like referrals for off-campus counselors for more frequent sessions. (CM)**

☐ **I would like to be connected to the Campus Violence Response Center.**

☐ I **need documentation of my mental health, medication, counseling services. (ROI)**

Counseling Center Non-Crisis Drop-In Hours:	Monday – Thursday: 12 pm – 5 pm & Friday 12 pm – 4 pm