|  |  |  |  |
| --- | --- | --- | --- |
| **Today’s Date:** | **First Name:** | **Last Name:** | **Preferred Name:** |
|   |  |   |   |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Preferred Pronoun:** | **Date of Birth:** | **Age:** | **Student I.D.:** | **Cell Phone:** | **OK to call?** |
|  |   |   |   |   |  ☐ |

|  |  |  |  |
| --- | --- | --- | --- |
| **Home Phone:** | **OK to call?** | **Preferred Email:** | **OK to email?** |
|   |[ ]    |[ ]

|  |  |  |
| --- | --- | --- |
| **Local Address: (OK to contact you at home?)** [ ]  |  | **Permanent Address:**  |
| Street:  |  | Street:  |
| City:  |  | City:  |
| State/ZIP:  |  | State/ZIP:  |

|  |
| --- |
| **Emergency Contact Person:**  |
| **Relationship to You:**   |
| **Phone:**   |

**What is your primary reason for seeking assistance? Please Describe:**

|  |
| --- |
|   |

**Does the reason for seeking assistance today involve any of the following (Please check all that apply):**

[ ]  Concerned about alcohol or drug use. Please describe:

[ ]  Discrimination/hate crime

[ ]  Loss/death of a significant person

[ ]  Harassment/stalking

[ ]  Physical or emotional abuse Past \_\_\_ and/or Present \_\_\_

[ ]  Sexual assault, past or current sexual abuse Past \_\_\_ and/or Present \_\_\_

[ ]  Thoughts of harming myself or another person Past \_\_\_ and/or Present \_\_\_

[ ]  Have deliberately injured myself

[ ]  Academic performance. Please describe:

|  |  |
| --- | --- |
| How often in the past year have you had more than (5 drinks in a day if you are male) (4 drinks in a day if you are female)? [ ]  Never [ ]  1 or More Times | How often in the past year have you used a recreational drug or used a prescription medication for non-medical reasons? [ ]  Never [ ]  1 or More Times |

**Please list any previous or current mental health therapy and any previous hospitalizations:**

|  |  |  |
| --- | --- | --- |
| Provider/Clinic | Condition/Issue | Date(s) |
|   |   |   |
|   |   |   |

**Please list any physical health concerns**

|  |
| --- |
|  |

**Please list any current medications (psychiatric, medical, and over-the-counter):**

|  |  |
| --- | --- |
| Medication: | Reason for Taking: |
|   |   |
|   |   |
|   |   |

**How would you describe your eating patterns & do you have an adequate food source?**

|  |
| --- |
|   |

**How would you describe your sleeping patterns?**

|  |
| --- |
|   |

|  |  |
| --- | --- |
| **Gender**: Please check box or fill in:[ ] Male [ ] Female [ ]  Transgender [ ]  Fluid [ ]  Non-Binary[ ] My own description:[ ]  Prefer Not to Answer | **Sexual Orientation**: Please check box or fill in:[ ] Asexual [ ] Bisexual [ ]  Gay [ ] Hetero/straight [ ] Questioning [ ]  My own description:[ ]  Prefer Not to Answer |

**Counselor Preferences:**

|  |  |
| --- | --- |
| Do you have a gender preference for your assigned counselor? |  [ ]  Male [ ]  Female [ ]  No preference  |
| Do you have a specific counselor with whom you would like to work? |  [ ]  No [ ]  Yes, name of preferred counselor:  |
| Do you have a preference for the race/ethnicity of your assigned counselor? |   [ ]  No [ ]  Yes, my preference is:  |

**Appointment Availability:** list days and times that don’t conflict with your classes or work. Appointments are scheduled for 50 minutes

|  |  |  |
| --- | --- | --- |
|  | **AM (8-12)** | **PM (12-4)** |
| Monday |  |  |
| Tuesday |  |  |
| Wednesday |  |  |
| Thursday |  |  |
| Friday |  |  |