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

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

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| --- | --- | --- |
| **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:**

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|  |

**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**

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| --- |
|  |

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

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| --- | --- |
| Medication: | Reason for Taking: |
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**How would you describe your eating patterns & do you have an adequate food source?**

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| --- |
|  |

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

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| --- |
|  |

|  |  |
| --- | --- |
| **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 |  |  |