Union University Counseling
Client Information Form

DIRECTIONS: Please complete the following form and bring with you to your first appointment. If you do not complete this form prior to your initial appointment, ***your appointment may need to be rescheduled.*** If you choose to complete it at the Counseling Center prior to your first appointment, please plan to come to your appointment **at *least fifteen before your scheduled time.*** Completion of this form is not mandatory in order to be seen at the Counseling Center, but doing so will enable us to provide you with more comprehensive and timely service. ***ALL INFORMATION IS CONFIDENTIAL!***

Date: _____ ID#_____ Referred by _____
Name: _____ Date of Birth: _____ Age: ____

Ethnicity: **(circle one)** *Non-Hispanic/Latino* *Hispanic/Latino*

Race: **(circle one)** *White/Non-Hispanic* *Black/African-American* *Unknown*
Asian *American Indian/Alaska Native* *Native Hawaiian/Pacific Islander*

Mailing Address: (please include personal and parent's)
Personal_____
_____
City State Zip
Parent's _____
_____
City State Zip

Phone: (Cell) _____ (May we call or leave a message at this number?) Y___N___
(Home)_____ (May we call or leave a message at this number?) Y___N___
E-Mail Address: _____(May we e-mail you?) Y___N___
(Note: Because e-mail is not confidential, we strongly discourage you from using e-mail to communicate sensitive information with your counselor.)

Roommate(s): (1)_____ (2)_____
(3)_____ (4)_____
Employment: _____Hrs. per week:_____

FAMILY INFORMATION:

	NAME	AGE	LEVEL OF EDUCATION	OCCUPATION
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Siblings	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

Parent's Address: _____City: _____State: _____Zip:_____
_____City: _____State: _____Zip:_____
Parent's Phone Number:(H)_____(W)_____(CP)_____
(H)_____(W)_____(CP)_____

ACADEMIC INFORMATION:

Classification: Freshman Sophomore Junior Senior Grad. Student
Hours attempted this semester: _____ Overall GPA: _____
Expected Date of Graduation: _____ Major: _____
Probable Occupation: _____

GENERAL INFORMATION:

Have you received services from the Union Counseling Center before? Y____N____
If yes, please check all that are applicable:
_____Counseling: Dates: _____

Have you previously received psychological/psychiatric services elsewhere? Y____N____
If yes, date(s) and type of service: _____
Have you ever been hospitalized for psychological/psychiatric care: Y____N____?
If yes, date(s) and reason: _____
Do you have any medical problems for which you are currently being treated? Y____N____
If yes, please explain: _____
Are you taking any medication(s)? Y____N____
If yes, please list: _____
Have you ever been arrested for or convicted of a crime? Y____N____
If yes, date(s) and reason for arrest(s) or conviction(s):
_____

FAMILY HISTORY: (Check any that are/were present in your family.)

Who in your family has experienced:
___Depression _____
___Anxiety _____
___Substance Abuse _____
___Suicide Attempt _____
___Physical Abuse _____
___Sexual Abuse _____
___Eating Disorder _____
___Other Psychiatric/Emotional Disturbance (explain)_____
_____
___None

Briefly describe the primary reason(s) you are seeking counseling and/or consultation:
_____
_____
_____

How are your concerns affecting you ACADEMICALLY? Check all that apply.
___Concentration ___Academic Probation ___Performance ___Failing Exam(s) ___Grades
___Missing assignment(s) ___Absenteeism ___Other _____
___None of the above

How are your concerns affecting you in other areas of your life? (i.e. socially, relationship, family, work, etc.)
_____
_____
_____

What are your goals for counseling? _____
_____

In what ways do you expect counseling to help you? _____
_____
_____

Who are the people in your life you will turn to for support while making changes in your life:
_____
_____

Please check any of the following concerns you are currently experiencing or have experienced:

Present	Past	
_____	_____	Anxiety
_____	_____	Depression
_____	_____	Bipolar disorder
_____	_____	Unwanted sexual experience
_____	_____	Sleep disturbance
_____	_____	Changes in appetite
_____	_____	Academic problem
_____	_____	Relationship concerns (e.g. break up, conflict)
_____	_____	Relationship violence (e.g. emotional, physical, sexual, verbal abuse)
_____	_____	Panic attacks
_____	_____	Shyness or Social Anxiety
_____	_____	Test Anxiety
_____	_____	Obsessive compulsive behavior
_____	_____	Phobia
_____	_____	Stress
_____	_____	Thoughts of suicide
_____	_____	Suicide attempt(s)
_____	_____	Self-Injury (e.g. cutting, burning, banging head, etc.)
_____	_____	Difficulty concentrating
_____	_____	ADHD
_____	_____	Low motivation or energy
_____	_____	Severe mood swings
_____	_____	Loneliness
_____	_____	Anorexia
_____	_____	Bulimia
_____	_____	Disordered eating
_____	_____	Anger management
_____	_____	Family concerns
_____	_____	Traumatic event
_____	_____	Physical abuse
_____	_____	Sexual abuse
_____	_____	Pornography use
_____	_____	Gambling
_____	_____	Recent death or loss

Present	Past	
_____	_____	Legal/Judicial Affairs problem
_____	_____	Alcohol abuse
_____	_____	Marijuana use
_____	_____	Other drugs (e.g. methamphetamine, cocaine, etc.)
_____	_____	Sexual dysfunction
_____	_____	Health concern
_____	_____	Work-related concern
_____	_____	Identity problem
_____	_____	Religious or spiritual problem
_____	_____	Cultural concerns
_____	_____	Excessive video or online game use
_____	_____	Other: _____

What do you see as your top 5 **strengths**?
1._____ 2._____3._____
4._____ 5._____

What do you do for self-care (i.e. hobbies, interests, etc.)?
_____

Please check the times when you are <u>AVAILABLE</u> for counseling.

	Monday	Tuesday	Wednesday	Thursday	Friday
8 am					
9 am					
10 am					
11 am					
12 pm					
1 pm					
2 pm					
3 pm					
4 pm					
5 pm					

<u>THANK YOU!!</u> **Please print this form and bring to your initial appointment.** You and your intake counselor will determine the most appropriate therapeutic service for your particular concern.