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.*** ***ALL INFORMATION IS CONFIDENTIAL!***

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

Ethnicity: **(choose one)** ◯ *Non-Hispanic/Latino* ◯ *Hispanic/Latino*

Race: **(choose 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
☐	☐	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.