

SCSU COUNSELING SERVICES – STUDENT/CLIENT INTAKE FORM

Side 1

Please note: All information is confidential except where limited by law. None of this information will become part of your permanent file at SCSU and all will all remain locked in this office. No information will be released without your express consent and in accordance with legal and ethical guidelines. This information is asked to better serve our clients. If you have any questions, please ask a staff member.

- Name: _____ ID # _____ SS# _____
- Gender: Male / Female / _____ Date of Birth: _____
Month Day Year
- Permanent Address: _____
Street Town State Zip
- Phone: (____) _____ Email address: _____
- Local Address: _____
Street Town State Zip
- Phone: (____) _____ Cell Phone (____) _____
- Place of Employment (if any): _____
- Ethnic Origin (optional):
_____ African American / Black _____ Asian American / Pacific Islander _____ Latino / Hispanic
_____ Native American / Alaskan Native _____ White / Non-Hispanic _____ Other: _____
- Year Entered SCSU: _____ Are you a transfer student: Yes No
If yes, from where? _____
- Status: *Full time* *Part time* *Residence Hall* *Commuter*
- Classification: *First year* *Sophomore* *Junior* *Senior* *Don't know*
Graduate *Staff* *Faculty*
- Expected Date of Graduation: Semester _____ Year _____
- Major: _____ GPA: _____

CONTACT INFORMATION:

May we contact you by: _____ home phone _____ cell phone _____ email (appointments only)

May we send information by mail to: _____ campus address _____ home address _____ do not send mail
 other - specify address: _____

PLEASE CONTINUE ON REVERSE SIDE

Side 2

- Emergency contact name & phone number:

Name Relationship to you () Phone number

- Are you currently receiving any of the following mental health services? Yes No

If yes, please circle all that apply:

MD Psychologist Social Worker Counselor Other: _____

- Have you previously been seen by any mental health professional? Yes No

If yes, by whom? _____ When? _____

- Do you have SCSU student health & accident insurance? Yes No Don't know

If no, please provide us with your private insurance information:

Insurance Company: _____

Policy Holder: _____ Policy Number: _____

- How were you referred to our services? (Circle those that apply)

Self Faculty/Advisor Health Services Workshop/Program Family Residence Life

Other SCSU Staff Women's Center Friend Other: _____

- Please describe your current relationship status:

Single In Relationship Married Divorced Separated

- Please read this checklist and check once the items of concern to you. Check twice those items which are of most concern and which you would like to discuss with your counselor.**

___ School work & grades ___ Shyness, being assertive ___ Procrastination, motivation
___ Self-esteem, self confidence ___ Test anxiety / speech anxiety ___ Loneliness
___ Depression ___ Decision about major/career ___ Adjustment to university
___ Anxiety, fears, worries ___ Relationship with friend/roommate ___ Irritable, angry, hostile feelings
___ Violent behavior ___ Sexual assault or abuse ___ Relationship with significant other
___ Sleep problems ___ Relationship with parents/family ___ Eating problems
___ Physical stress (i.e. headaches, nausea, aches/pains) ___ Alcohol, drugs, substance abuse
___ Suicidal feelings/behavior ___ Loss of significant person/ relationship ___ Sexual concerns
___ Gay/lesbian/Bisexual/transgender issues ___ Other _____

Optional:

In the space below, please write in a sentence or two the primary reason you are seeking help.

In general, how much does this problem bother you?

___ *A little* ___ *Pretty much* ___ *Very much* ___ *Couldn't be worse*

Do you think this problem interferes with your academic performance? ___ Yes ___ No