UIW Counseling Services Intake Form

Name:_____Date_____
(Last) (First) (M.I.)
Name you wish to be called:_____ Age:_____ Date of birth:_____

Address:_____
Phone number:_____ May we leave voice messages:_____

Preferred email address:_____ Student ID: _____

Classification: ☐ High School ☐Undergraduate ☐ Graduate ☐ Nursing ☐ Master of Biomedical Sciences ☐ Nursing ☐ Optometry ☐ Osteopathic Medicine ☐ Pharmacy ☐ Physical Therapy Major(s):_____

Gender: ☐ Male ☐ Female ☐ Do not wish to disclose

Gender Identity: ☐ Male ☐ Female ☐ Transgender M-F ☐ Transgender F-M ☐ Genderqueer/ Gender Non-Binary ☐ Other

Sexual Orientation: ☐ Heterosexual ☐ Lesbian or Gay ☐ Bisexual ☐ Questioning ☐ Other:_____

Racial/ethnic identity (check all that apply): ☐ Caucasian ☐ African American or Black ☐ Hispanic of Latino ☐ Asian (including Indian subcontinent) or Pacific Islander ☐ Other:_____

Is religion or spirituality important you: ☐ Yes, religion: _____ ☐ No

Do any of the following describe you? (Check all that apply)
☐ First-generation college student (parents/guardians did not graduate from a 4-year college)
☐ Intercollegiate athlete
☐ Member of TRIO Program
☐ Veteran
☐ Have a disability. Please list _____
☐ Registered with Student Disability Services? ☐ No ☐ Yes
- If no, interested in being connected with Student Disability Services? ☐ Yes ☐ No

Who referred you to Counseling Services: _____

Have you previously seen a counselor at Counseling Services? ☐No ☐ Yes

Emergency Contact Name: _____
Phone #: _____Relationship: _____

Are you experiencing an emotional crisis today? ☐ No ☐ Yes
Rate your distress *right now* on a scale of 0 (no distress) to 10 (extreme distress) _____

Which of the following best describe why you would like to speak with a counselor? (Check all that apply.)

☐ Personal or Relationship Concern (e.g. depression, anxiety, stress, low energy, relationships)
☐ Recent physical or sexual assault
☐ Grief or Loss (recently lost a loved one or pet)
☐ Having trouble adjusting to recent changes in life or unsure about future
☐ Substance use concern (worried about alcohol or drug use)
☐ Eating concern (eating too much, not enough, purging or using medications to purge)
☐ Academic performance/ grade concern (e.g., test anxiety, study skills, time management, struggling with exams or major, or other issue)
☐ Learning Assessment (you think you have a learning disability or disorder that impacts you academically)
☐ Seeking an off-campus referral (seeking specialty service or resource)
☐ A required consultation, evaluation or assessment (e.g. by Student Conduct, Dean, Athletics, Internship)
☐ Concern about another person
☐ Seeking one consultation visit only (worried about someone, just want to ask a question/ address one concern, or need to make a major life decision in near future)
☐ Group counseling (please check group interested in attending)

- ☐ Coping with Anxiety ☐ Managing Emotion: Working through Depression
- ☐ Navigating Relationships ☐ Connecting through Movement
- ☐ Cinematherapy: Movies as Therapy

☐ Considering withdrawing from UIW? ☐ No ☐ Yes

What specific concerns would you like to discuss with a counselor?

_____

_____

_____

Have you been diagnosed with any of the following mental health disorders? (Check all that apply.)

☐ Attention Deficit/Hyperactivity Disorder
☐ Learning Disorder
☐ Depression
☐ Anxiety Disorder
☐ Post Traumatic Stress Disorder
☐ Bipolar Disorder
☐ Eating Disorder
☐ Personality Disorder
☐ Substance Use Disorder
☐ Other: _____

Have you ever taken prescribed medication for a mental health concern? (Check all that apply.)
☐ No ☐ Yes, before starting university ☐ Yes, after starting university ☐ Yes, I am currently taking medications

Please list any medications you are currently taking:

Medication	Dose	Prescribed by

Do you have any medical conditions? If so, please list below and your treating provider.

_____

_____

_____

Substance Use:

Have you recently (within the last 12 months) been under the influence of alcohol or other chemicals? ☐ No ☐ Yes (explain)

Amount: _____ Last Use:_____

Factors related to substance use:

☐ Recent increase in use

☐ Using substances to relieve mental health symptoms

☐ Use of drugs/alcohol worsens mental symptoms

☐ Substance is interfering with work/school/mental health treatment program

☐ Family/Friends complain about substance use

☐ Feeling shaking, agitated, irritability, restlessness, stomach cramps, insomnia, pain in muscles, mental confusion, clammy skin, sweating, diarrhea, blackouts, tremors, or severe anxiety (circle all that apply)

☐ Have had Emergency Room visits or hospitalizations due to drug/alcohol use

History of Substance Use:

Substance	Amount	Pattern of Use	Duration of Use	Age Started Using	Last Time Used	Amount in past 24 hours

Previous Treatment for Substances Abuses/Response to Previous Treatment:

_____

Legal Issues due to Substance Abuse:

☐ None ☐ Yes (explain) _____

PHQ-2

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless				

GAD-2

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge				
2. Not being able to stop or control worrying				