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: _________________

Preference for session: ☐ In-person ☐ Zoom ☐ Either

Please provide your available times for an appointment:

____
____
____
____
____

Classification: ☐ High School ☐ Undergraduate ☐ Graduate ☐ Nursing ☐ Optometry ☐ SOM
☐ Master of Biomedical Sciences ☐ Pharmacy ☐ Physical Therapy

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/Black ☐ Hispanic/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
☐ Intercollegiate athlete
☐ Member of TRIO program
☐ Veteran
☐ Have a disability?

- If yes, have you registered with Student Disability Services? ☐ Yes ☐ No
- If no, are you interested in being connected with Student Disability Services? ☐ Yes ☐ No

Were you referred to Behavioral Health Services? ☐ Yes ☐ No
If so, by whom? ____

Have you previously been a client of UIW Behavioral Health Services? ☐ Yes ☐ No

Emergency Contact Name: ____________________________________
Phone #: __________________________________ Relationship: ________________________________

Are you experiencing an emotional crisis today? ☐ Yes ☐ No
Rate your current level of distress on a scale of 0 (no distress) to 10 (extreme distress) _________
Which of the following best describes why you would like to speak with a counselor? (Check all that apply)

☐ Personal or Relationship Concern
☐ Recent physical or sexual assault
☐ Grief or Loss
☐ Having trouble adjusting to recent changes in life or unsure about future
☐ Substance use concerns
☐ Academic performance/grade concerns
☐ Career concerns
☐ Seeking an off-campus referral (e.g., specialty care)
☐ Seeking one-time consultation (e.g., have a question, concern for another student)
☐ Considering withdrawing from UIW?
☐ Other: ____

What specific concern(s) would you like to discuss with a counselor?
____
____
____

Have you been diagnosed with any of the following diagnoses? (Check all that apply)

☐ Attention Deficit/Hyperactivity Disorder
☐ Learning Disorder
☐ Depressive disorder
☐ Anxiety disorder
☐ Post Traumatic Stress Disorder (PTSD)
☐ Bipolar I or II Disorder
☐ Eating Disorder
☐ Personality Disorder
☐ Substance Use or Abuse Disorder
☐ Other: ____

Have you ever been prescribed medication for a mental health concern?

☐ Yes
☐ Yes, before starting at UIW
☐ Yes, since I started at UIW
☐ No

- If yes, are you currently taking your prescribed medication? ☐ Yes ☐ No

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 current treating provider.

____
____
____
____

Substance Use:

Have you recently (within the last 6 months) been under the influence of alcohol or other chemicals?
☐ No ☐ Yes, please explain:

____
____
____
____

What substances have you used in the past?

☐ Alcohol
☐ Marijuana
☐ Nicotine
☐ Narcotics
☐ Hallucinogens
☐ Inhalants
☐ Other: ____

Factors/impact related to substance use: (check all that apply)

☐ Recent increase in use
☐ Using substances to relieve mental health symptoms.
☐ Use of substances worsens mental health symptoms.
☐ Substance use is interfering with work/life/school/relationships
☐ Others complain about my substance use
☐ Physical symptoms of substance use (e.g., shaking, sweating, irritability, restlessness, insomnia, etc.)
☐ Been hospitalized or being to residential treatment due to substance use

- If so, where: ____________________________ when: ______________________

☐ Legal issues due to substance use? ☐ Yes ☐ No
☐ Other: ____

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	☐	☐	☐	☐