

Union University Counseling Client Information Form

DIRECTIONS: Please complete the following form and bring with you to youst tappointment. If you do not complete this form prior to your initial appointment, your appointment may need to be desired. If you choose to complete it at the Counseling Center prior to your first appointment, please plan to come to your appointment ateast fifteenbefore your scheduled timeALL INFORMATION IS CONFIDENTIAL!

Date:	ID#	F	Referred by		
Name:		D	Referred by ate of <u>Birth:</u>	Age:	
Ethnicity: (choose or	ne) Non-Hispan	ic/Latino	Hispanic/Latino		
Race: ¢hoose one) White/NonHis Asian American Indian/Al		•	Black/AfricanAmer Native H	ican Unkı Hawaiian/Pacific Is	nown slander
Mailing Address: (pl Persona <u>l</u>			ťs)		
	ity	State	Zip		
Phone: (Cell)(Home) E-Mail Address:	(May	State we call or leave we call or leave	Zip ve a message at this ve a message at this(May we e-m om usingaë to communicate	num <u>ber?NY</u> ail vou?) N Y	ith your counselo
			(2)		_
(3) Employment:			(4) Hrs per	week:	-
FAMILY INFORMATION NAME Father Mother	ΓΙΟΝ: AGE	LEVEL OF	·	CCUPATION 	
		City:	State: Stat <u>e:</u>		
Parent's Phone Nur	nber:(<u>H)</u> (H)	(<u>W)</u> (<u>W)</u>	(CP) (CP)	21p	
ACADEMIC INFOR Classification: Hours attempted thi Expected Date of & Probable Occupation	Freshman Sopl s semest <u>er:</u> duation:	Overa	nior Senior ıll GP <u>A:</u> r:		ent

GENERAL INFORMATION:
Have you received services from the Union Counseling Center before? M
If yes, please check all that are applicable:
Counseling: Dates:
Have you previously received psychological/psychiatric services elsewhere? N
If yes, date(s) and type of service:
Have you ever been hospitalized for psychological/psychiatric care? Y
If yes, date(s) and reason:
Do you have any medical problems for which you are currently being treated? M
If yes, please explain
Are you taking any medication(s)? Y N N If yes, please list:
Have you ever been arrested for or convicted of a crime? YN
If yes, date(s) and reason for arrest(s) or conviction(s):
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.
ConcentrationAcademic ProbationPerformancealling 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.)
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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:				
	k any of the following concerns you are currently experiencing or have experienced:			
<u>Presen</u> t	<u>Pas</u> t			
	Anxiety			
	Depression			
	Bipolar disorder			
	Unwanted sexual experience			
	Sleep disturbance			
	Changes in appetei			
	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)			
	Selfinjury (e.g. cutting, burning, banging head, etc.)			
	Dfficulty 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			
	Workrelated concern			
	Identity problem			
	Religious or spiritual problem			
	Cultural concerns			
	Excessive video or online game use			
	Other:			

What do you see as your top 5 stre	engths	
1	2	3
4.	5.	
What do you do for selfare (i.e. ho	bbies, interests, etc.)?	
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Please check the times when you are AVAILABLE 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					