Benedictine University

Counseling Center Intake Information Form

Date _____

Name and Student ID# _____

Phone Number (where you can be reached or a message left): _____

On campus resident student: _____ Commuter student: _____

Address where we can reach you by mail: _____

_____

Gender: Female _____ Male _____ Transgender _____ Other _____ Age_____

Date of Birth: (month/day/year) _____ Ethnic/Racial Origin _____

When did you begin at Benedictine University: _____ Expected graduation date: _____

Educational History: (other colleges/universities attended, dates, graduations) _____

_____

Full Time Student: _____ Part Time Student: _____ Are you a student athlete: Yes ____ No ____

What is your major: _____

Current Credit Hours: _____ GPA: _____

Please check all that apply:

Referred By:	**College Status:**	**Sexual Orientation:**	**Relationship Status:**
Self _____	Freshmen _____	Heterosexual _____	Single _____
Advisor/Faculty/Staff _____	Sophomore _____	Gay/Lesbian _____	Married _____
Residence Hall/RA _____	Junior _____	Bisexual _____	Partnered _____
Brochure/Advertisement _____	Senior _____	Asexual _____	Divorced _____
Family _____	Graduate Student _____	Questioning _____	Widowed _____
Other _____		Other _____	Separated _____

Non-academic work:
Hours per week _____

Spirituality/Religion:
Is spirituality or religion an important part of your life? Yes _____ No _____

Family Background
Father: Age _____ Occupation _____
If deceased, how old were you when he died? _____
Mother: Age ___ Occupation _____
If deceased, how were you when she died? _____
Marital Status of Parents:
Married _____ Separated _____ Divorced _____ Never Married _____ Widowed _____
Partnered _____
Number of Brothers: _____ Ages: _____
Number of Sisters: _____ Ages: _____
Spouse/Partner: _____ Age: _____
Number of Children: _____ Ages: _____
Other significant family members: _____

Do you or anyone in your immediate family have a current or past problem with any of the following?

Check all that apply:	If yes, who?
_____ Alcohol, Substance Abuse	_____
_____ Depression	_____
_____ Anxiety Disorder	_____
_____ Psychological/Emotional Disorder	_____
_____ Eating Disorder	_____
_____ Suicide	_____
_____ Criminal Activity	_____

Are you concerned with any of the following eating/body images?
Check all that apply:

_____ Frequently dieting	_____ Excessive exercise	_____ Vomiting
_____ Using Laxatives	_____ Reducing food intake	_____ Binge eating
_____ Emotional Eating	_____ Body image	_____ Other (please describe)
		_____

Have you ever experienced any of the following traumas?
Chick all those apply:

_____ Physical Abuse	_____ Emotional/Verbal Abuse	_____ Bullying
_____ Childhood Sexual Abuse	_____ Sexual Assault/Rape	_____ Other

Previous Psychological Treatment

Are you currently seeing a counselor? No _____ Yes_____

Have you been in counseling before? No _____ Yes _____

If yes, when/where? _____

Have you ever taken psychotropic medications? No _____ Yes _____

If yes, please list medication(s) taken, dosage, and how long taken: _____
_____

Have you ever attempted suicide? No _____ Yes _____
If yes, when? _____

Do you have memory loss, non-alcoholic related blackouts or "lose time"? No _____ Yes _____

Have you ever self-injured? No _____ Yes _____
If yes, when? _____

Have you ever had a problem with alcohol or drug use? If so, explain? _____

Have you ever experienced auditory or visual hallucinations? No _____ Yes _____

Are you currently having suicidal thoughts or feeling suicidal? No _____ Yes _____

Are you currently having homicidal thoughts or feeling homicidal? No _____ Yes _____

Alcohol, Drug, and Internet Use

How many days per week do you use alcohol or other drugs? _____ days per week

If one or more days, list substance(s) used: _____

How much of the above substances do you use on those days? _____

What is the most you had to drink or use on any one day over the past 3 months? _____

If you used any substances before age 15, please list them: _____

Do you smoke cigarettes? No _____ Yes _____
If yes, how many cigarettes do you smoke per week? _____

How many hours per day do you spend on the Internet? _____ hours per day

Physical Health

Do you have any current or past medical problems? No _____ Yes _____
If yes, please describe: _____
Are you regularly taking medication? No _____ Yes _____
If yes, please list medication and dosage: _____

Please rate all the items below on a scale from Zero to 3. 0 = No Concern 3 = Great Concern

Your honest answers will enable your counselor to be more helpful to you.

_____ Adjustment to College
_____ Alcohol/Drug Use
_____ Anger
_____ Anxiety
_____ Choosing a Career
_____ Choosing a Major
_____ Concern for Welfare of another person
_____ Depression
_____ Disability
_____ Discrimination
_____ Eating Problems
_____ Ethnic Identity Concerns
_____ Fearing Failure
_____ Financial Matters
_____ Grief/Loss/Death
_____ Judicial/Legal Matters
_____ Loneliness/Homesick
_____ Loss of Friendship
_____ Panic Attacks
_____ Past Family Problems
_____ Peer Relationships
_____ Physical Concerns
_____ Pregnancy
_____ Recurring Dreams
_____ Self-Confidence or Self-Esteem Issues
_____ Sexual Abuse
_____ Sexual Harassment
_____ Sexual Identity Concerns
_____ Sexuality
_____ Sexually Transmitted Disease
_____ Sleep Problems
_____ Spirituality
_____ Stress
_____ Studying Effectively
_____ Time Management
_____ Traumatic Event
_____ Worry about Grades/School
_____ Other (explain): _____
_____

Please briefly describe what brings you to the Counseling Center:

_____
_____
_____
_____
_____
_____

Thank You!