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| For Office Use Only  Audio Y / N Video Y / N |

ISU Student Counseling Center

This is your first appointment with one of our counselors, and we want to make this visit as comfortable as we can for you. We are asking that you complete this form with some important information that will help the counselor know specifically why you needed to come in today and how to best assist you. Please feel free to ask any questions of your counselor.  
If you are filling this out electronically, PLEASE DO NOT USE THE HIGHLIGHTER FUNCTION to make your choices. Thank you.

##### **FACTS ABOUT YOU**

# Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ University ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are you currently enrolled at ISU? Yes or No

# Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Birth:** \_\_\_/\_\_\_/\_\_\_ **Age**: \_\_\_\_\_\_ **Gender Identity:** \_\_\_\_\_\_\_\_\_\_\_\_  **Pronouns**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Local Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_**

**Permanent Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_**

**OK to contact by mail?** **Yes or No Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OK to leave message? Yes or No**

**ISU E-mail Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_@sycamores.indstate.edu OK to send a message? Yes or No**

**Emergency Contact**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Emergency Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relationship to You**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Note: We will only contact in case of an extreme emergency.*

**Classification:** Freshman Sophomore Junior Senior Graduate

**Major**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **GPA** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Enrollment:** Full-Time / Part Time

**College:** College ofArts and Science Scott College of Business Bayh College of Education

College of Technology Health and Human Services College of Graduate and Professional Studies

**Relationship Status:** Single Partnered Married Divorced Separated Other\_\_\_\_\_\_\_\_\_\_\_\_

**Ethnicity:** Black/African American Caucasian Native American Asian Latino (a) Other/Specify: \_\_\_\_\_\_\_\_\_\_\_\_

**Who Referred You:** Self Residence Hall Friend Student Conduct and Integrity Student Health Ctr. Family Academic Services Physician Faculty Disability Services Dean of Students Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Citizen Status:** US Citizen International Student US Resident- Non Citizen DACA

**Living With:**  Alone Roommate Parents/Family Significant Other Other \_\_\_\_\_\_\_\_\_\_\_\_

**Residence:** Residence Hall Off-Campus Fraternity/Sorority Other\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you currently employed?** \_\_\_\_\_Yes \_\_\_\_\_No **Do you currently have health insurance?** \_\_\_\_\_\_Yes \_\_\_\_\_\_No

**Sexual Orientation:** Heterosexual Bisexual Gay Lesbian Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Military Status:** No military service Veteran Service-Disabled Veteran Current Reserve/Guard

**Are you an ISU Athlete?**  Yes No **Are you a first-generation college student?** Yes No

***AVAILABILITY: Times you are Free: Please check inside the boxes for all available hours for your appointments.***

**SEMESTER: FALL SPRING SUMMER**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Monday | 8-8:50 | 9-9:50 | 10-10:50 | 11-11:50 | 12-12:50 | 1-1:50 | 2-2:50 | 3-3:50 | 4-4:50 |
| Tuesday | 8-8:50 | 9-9:50 | 10-10:50 | 11-11:50 | 12-12:50 | 1-1:50 | 2-2:50 | 3-3:50 | 4-4:50 |
| Wednesday | 8-8:50 | 9-9:50 | 10-10:50 | 11-11:50 | 12-12:50 | 1-1:50 | 2-2:50 | 3-3:50 | 4-4:50 |
| Thursday | 8-8:50 | 9-9:50 | 10-10:50 | 11-11:50 | 12-12:50 | 1-1:50 | 2-2:50 | 3-3:50 | 4-4:50 |
| Friday | 8-8:50 | 9-9:50 | 10-10:50 | 11-11:50 | 12-12:50 | 1-1:50 | 2-2:50 | 3-3:50 | 4-4:50 |

\*The more availability you have the quicker it is to get off of the waitlist. If you only have One hour on One day the wait may be longer.\*

#### CONCERNS ABOUT YOU

**Previous Treatment:**

**Have you ever been to the Student Counseling Center Before?** Yes No  **If Yes, whom did you see? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Are you currently being seen by a therapist?**  Yes No

**Other treatment:** \_\_\_Private Therapist \_\_\_\_Psychiatric Hospitalization \_\_\_Community Mental Health Other\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please describe briefly what brings you to the Counseling Center today: (e.g., I have anxiety all the time).**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Medical:

Disability: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physical / Medical Problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How well do you take care of yourself (e.g., eating, sleeping, hygiene, etc.)? **Good Fair Poor**

How would you rate your social support? **Good Fair Poor**

How would you rate your academic functioning? **Good Fair Poor**

**Have you had recent thoughts about killing yourself or someone else? *Yes / No* If yes, when did you last have these thoughts? *Today Last Night A Couple of Days Ago Last Week Two weeks Ago Last Month***

**Have you seriously thought about suicide before? *Yes / No* Have you ever attempted suicide? *Yes / No***

**Have you ever physically hurt yourself in any way? *Yes / No* Have you ever physically hurt someone else? *Yes / No***

**Problem Areas: Please check which problems apply to you from the list below. Leave those items BLANK that do not apply.**

\_\_\_Alcohol or drug problems \_\_\_Sexual issues/STDs \_\_\_Depression

\_\_\_Childhood sexual abuse/molestation \_\_\_Pregnancy/abortion issues \_\_\_Discrimination

\_\_\_Attention, concentration, distractibility \_\_\_Relationship with family \_\_\_Legal matters

\_\_\_Compulsions or obsessions \_\_\_Rape/sexual assault \_\_\_Finances

\_\_\_Sexual harassment \_\_\_Religious/spiritual issues \_\_\_Self-mutilating behaviors

\_\_\_Anxiety, fears, worries \_\_\_Relationships with friends \_\_\_Sleep problems

\_\_\_Motivation, time management, grades \_\_\_Shyness/assertiveness issues \_\_\_Gender identity issues \_\_\_Decisions about career or major \_\_\_Irritable, angry, hostile feelings \_\_\_Sexuality

\_\_\_Suicidal thoughts/behavior \_\_\_Living situation/roommate \_\_\_ Homelessness

\_\_\_Loss/death of significant person \_\_\_Physical stress \_\_\_ Food Insecurity

\_\_\_Relationship with significant other \_\_\_Eating problems \_\_\_ Abusive Relationship

\_\_\_Coming out issues \_\_\_Self-esteem or worth issues \_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Body image issues \_\_\_Childhood physical/emotional abuse or neglect

\_\_\_Adjustment to University, lonely, homesick \_\_\_Chronic health problems or physical disability

**Please tell us about your use of alcohol and or other drugs: (circle one)**

I consume 4-5 drinks in a 24-hour period.

Never seldom 1x month 2x month weekly daily

**I have missed class, work, or other important functions as a result of alcohol or drug use**.

Never seldom 1x month 2x month weekly daily

**I have engaged in high-risk behaviors as a result of drinking or drug use (i.e. drinking and driving, sex, fights, etc.).**

Never seldom 1x month 2x month weekly daily

I have gotten in trouble with the law or Student Judicial Programs as a result of my alcohol or drug use.

Never seldom 1x month 2x month weekly daily

I have had others express concern to me because of my alcohol or drug use?

Never seldom 1x month 2x month weekly daily