STUDENT HEALTH SERVICES INTAKE FORM

Name:	Today's Date:
Date of Birth:	Student No:

I am requesting the following services from the Student Health Center (please mark all that apply):

- Learning Disability Assessment
- Attention Deficit/Hyperactivity Assessment
- Individual Therapy
- Group Therapy
- Couple's Therapy
- Medication Referral
- Request for Letter
- Other_____

Main Purpose Of The Consultation (Please give a brief summary):_____
_____
_____

What Brings You in Today? (Check all that apply):

- ☐ Depression
- ☐ Anxiety
- ☐ Grief and loss
- ☐ Relationship issues
- ☐ Eating and body image concerns
- ☐ LGBTQ issues/affirmative therapy
- ☐ Sexual concerns
- ☐ Trauma (e.g., war, rape, assault, natural disaster, abuse)
- ☐ Anger
- ☐ ADHD/Inattention
- ☐ Self-harming behaviors
- ☐ Academic difficulties
- ☐ Moodiness/fluctuating moods/irritability
- ☐ Unusual experiences (thoughts, beliefs, and/or perceptions)
- ☐ Addiction (e.g., drug, alcohol, gambling, gaming, pornography)
- ☐ Current suicidal thoughts*
- ☐ Other: _____

***If you have marked this box and don't have an appointment today, please contact the front desk and ask for an emergency appointment. If our office is not currently open, please call 911 or go to the ER.**

MEDICAL HISTORY

Are you currently taking any medication(s)?	Yes	No	List:	_____
Current supplements/vitamins/herbs?	Yes	No	List:	_____
Current medical problems?	Yes	No	List:	_____
Any history of head trauma?	Yes	No	Describe:	_____
Prior psychiatric hospitalizations?	Yes	No	Describe:	_____
History of thyroid problems?	Yes	No	Describe:	_____

If you have any other medical problems, please list them:
_____
_____

SOCIAL HISTORY

Have you ever used illicit drugs (i.e. marijuana, cocaine or amphetamines)? Yes No
If so, which drug(s)? _____
Do you have a regular exercise program? Yes No
If so, list activity and frequency _____
Do you smoke or use smokeless tobacco? Yes No
If so, list number of cigarettes/packs per day?_____

Do you drink alcoholic beverages? Yes No
If so, list amount and frequency: _____
If so, what do you generally drink? _____
Are you currently sexually active? Yes No
If yes, do you use contraception? Yes No
Have you ever been assaulted verbally, sexually, or physically? Yes No
Do you ever withhold food, exercise to excess, binge and purge, or use laxatives/diuretics to lose weight? Yes No
Are you currently seeing a therapist, health educator, psychologist or psychiatrist? Yes No
If yes, name of therapist _____

FAMILY HISTORY

Does anyone in your family have any of the following? *(Please circle. Include parents, grandparents, sibs, & children):*

Alcoholism Drug Abuse AD/HD Schizophrenia Bipolar Disorder (manic depression)
Depression Anxiety Personality Disorder Eating Disorder Thyroid Disease Heart Disease

How many siblings do you have?_____ What is your birth order?_____

CURRENT LIFE STRESSES

How well are you getting along at this time? ☐ Very Well ☐ Good ☐ Fair ☐ Poor

Have you had any significant life events? (Circle all that apply)
Marriage Separation Divorce Death Birth of Child Upcoming Graduation Abuse Traumatic Event

Are you having problems with any of the following? (Circle all that apply)
Relationships Job School Finances

SYMPTOMS

Symptoms present during the past month (please check all that apply):

- ☐ Sad, blue or depressed
- ☐ Loss of Interest in activities
- ☐ Feelings of worthlessness
- ☐ Feelings of hopelessness
- ☐ Feelings of guilt
- ☐ Recent weight gain
- ☐ Recent weight loss
- ☐ Sleeping too much
- ☐ Not able to sleep
- ☐ Poor concentration
- ☐ Low energy
- ☐ Low self-esteem
- ☐ Thoughts of death
- ☐ Decreased need for sleep
- ☐ Cannot stay focused
- ☐ Addictive behaviors
- ☐ Other:_____
- ☐ Inflated self-esteem
- ☐ Increased energy
- ☐ Increased activity level
- ☐ Happier than normal
- ☐ Talking too much
- ☐ Expansive thinking
- ☐ Restlessness
- ☐ Excessive worry
- ☐ Irritability
- ☐ Tense muscles
- ☐ Confused thinking
- ☐ Situational fears
- ☐ Sudden panic or fear
- ☐ Doing things over and over again
- ☐ Constant intrusive thoughts
- ☐ Re-experiencing frightening event(s)
- ☐ Nightmares/recurrent dreams
- ☐ Avoidance of a feared situation
- ☐ Seeing things others can't see
- ☐ Hearing things others can't hear
- ☐ Thoughts others will harm you
- ☐ Disorganized thoughts
- ☐ Decreased memory
- ☐ Intense fear of weight gain
- ☐ Vomiting for weight control
- ☐ Laxatives for weight control
- ☐ Difficulty controlling anger