# Student Counseling Center

Troy University

## INTAKE FORM

Welcome to the Troy University Student Counseling Center. Please complete this form honestly and to the best of your ability. Doing so will give us a better understanding in addressing your needs.

| First Name: | Middle Initial: | Last Name: | Preferred Name: |
|---|---|---|---|
| | | | |

**1.** Date of Birth: _____/_____/_____

Current Age: _____

**2.** Gender: _____

**3.** Troy ID or SSN#: _____

**4.** Primary Phone: _____

May our office call you? ☐ Yes ☐ No

**5.** May our office text appointment reminders to your cell phone? ☐ Yes ☐ No

If yes, please answer the following:

Cell phone number: _____

Name of cell phone provider: _____

**6.** Troy E-mail:

_____

May we e-mail you? ☐ Yes ☐ No

**7.** Mailing Address:

_____
Street

_____
City State

_____
Zip

**8.** Emergency Contact Information:

Name: _____

Relation: _____

Address: _____

_____

Phone: _____

**9.** Relationship Status:

- ☐ Single
- ☐ Serious dating or committed relationship
- ☐ Married
- ☐ Civil union/Domestic partnership
- ☐ Divorced/Separated
- ☐ Widowed

**10.** Race:

- ☐ African-American/Black/African
- ☐ Asian American/Asian
- ☐ European American/White/Caucasian
- ☐ Hispanic/Latino/Latina
- ☐ Multi-Racial
- ☐ Other (please specify): _____

**11.** Sexual Orientation (Optional):

- ☐ Heterosexual
- ☐ Gay
- ☐ Lesbian
- ☐ Bisexual
- ☐ Questioning
- ☐ Other: _____

**12.** Troy Status:

- ☐ Freshman
- ☐ Sophomore
- ☐ Junior
- ☐ Senior
- ☐ Graduate Student
- ☐ Other: _____

**13.** Major: _____

**14.** GPA: _____

**15.** Do you have health insurance?

☐ Yes ☐ No

**16.** Are you a Troy student athlete? ☐ Yes ☐ No

If yes, which team? _____

**17.** Are you an international student? ☐ Yes ☐ No

If yes, please list country of origin: _____

**18.** Who referred you to our office?

- ☐ Self
- ☐ Friend
- ☐ Parent or relative
- ☐ University housing staff
- ☐ Coach or athletic team staff member
- ☐ Dean of Student Services
- ☐ Physician/ Nurse
- ☐ Faculty/Staff (please provide name): _____
- ☐ Other: _____

Do we have permission to acknowledge the referral? ☐ Yes ☐ No If yes, please provide signature: _____

(*This permission allows us to reveal that you followed up on the referral with this appointment*.)

**19.** Please list any current medical conditions and/ or any medications you are taking:

_____

_____

_____

_____

**20.** Has anyone in your family been diagnosed with and/or treated for a mental health issue? If so, please list their relationship to you (i.e. mother, father, brother, etc.) and what they were treated for:

_____

_____

_____

_____

**21.** Reason(s) for Visit (check all that apply):

- ☐ Family Problems
- ☐ Romantic Relationship Issues
- ☐ Friendship/Roommate Problems
- ☐ Fighting/Anger Management
- ☐ Stress
- ☐ Anxiety
- ☐ Depression
- ☐ Illness
- ☐ Self-Esteem Issues
- ☐ Difficulty Adjusting to College
- ☐ Eating Concerns/Eating Disorder
- ☐ Spiritual/Religious Issues
- ☐ Mood Fluctuations
- ☐ Self-Mutilation
- ☐ Grief/Loss
- ☐ Sexual Harassment/Assault
- ☐ Dating/Domestic Violence
- ☐ Suicidal Thoughts
- ☐ Alcohol Use/Abuse
- ☐ Drug Use/Abuse
- ☐ Psychosis (*Delusions, Hallucinations)*
- ☐ Sexuality Issues
- ☐ Concern for Other
- ☐ Academic/Learning Concerns
- ☐ Witnessed/Experienced a Traumatic Event
- ☐ Other: _____

**22.** Have you or someone you know ever been the victim of a crime, e.g., sexual assault, dating/domestic violence, childhood abuse, stalking, robbery, assault, homicide, arson, bullying, etc.? ☐ Yes ☐ No

**Please indicate if/when you have had the following experiences:**

**23.** Have you attended mental health counseling before today? Yes: _____ No: _____ If you checked yes, please answer the following:

Where did you receive counseling? _____

When did you receive counseling? _____

What were you treated for? _____

**24.** Have you ever taken a prescribed medication for a mental health issue? Yes: _____ No: _____ If you checked yes, please answer the following:

What type of medication were you prescribed? _____

When were you prescribed this medication? _____

How long did you take this medication? _____

**25.** Have you ever been hospitalized for a mental health issue? Yes: _____ No: _____ If you checked yes, please answer the following:

When were you hospitalized? _____

What were you hospitalized for? _____

Where were you hospitalized? _____

How long were you hospitalized? _____

**PERSONAL COUNSELING IS CONFIDENTAL. HOWEVER, INFORMATON DISCUSSED IN SESSION(S) MAY NEED TO BE RELEASED IN CASE OF THREAT OF HARM TO SELF OR OTHERS, CHILD ABUSE/NEGLECT, VULNERABLE ADULT ABUSE/NEGLECT, OR IF ORDERED BY A COURT SUBPOENA.**

**SIGNATURE_____ DATE_____**