

# 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: _____
<b>1.</b> Date of Birth: ____/____/____	<b>2.</b> Current Age: _____	<b>3.</b> Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
<b>4.</b> Primary Phone: _____ May our office call you? <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>5.</b> Troy Email _____ May we e-mail you? <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>6.</b> Troy ID or SSN#: _____	
<b>7.</b> Mailing Address: _____ _____ _____	<b>8.</b> Emergency Contact Information: Name: _____ Relation: _____ Address: _____ _____ Phone: _____	<b>9.</b> Relationship Status: <input type="checkbox"/> Single <input type="checkbox"/> Serious dating or committed relationship <input type="checkbox"/> Married <input type="checkbox"/> Civil union/Domestic partnership <input type="checkbox"/> Divorced/Separated <input type="checkbox"/> Widowed	
<b>10.</b> Race: <input type="checkbox"/> African-American/Black/African <input type="checkbox"/> Asian American/Asian <input type="checkbox"/> European American/White/Caucasian <input type="checkbox"/> Hispanic/Latino/Latina <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Other (please specify): _____	<b>11.</b> Sexual Orientation (Optional): <input type="checkbox"/> Heterosexual <input type="checkbox"/> Gay <input type="checkbox"/> Lesbian <input type="checkbox"/> Bisexual <input type="checkbox"/> Questioning	<b>12.</b> Troy Status: <input type="checkbox"/> Freshman <input type="checkbox"/> Graduate Student <input type="checkbox"/> Sophomore <input type="checkbox"/> Other: <input type="checkbox"/> Junior <input type="checkbox"/> _____ <input type="checkbox"/> Senior	
<b>13.</b> Major: _____	<b>14.</b> GPA: _____	<b>15.</b> Do you have health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>16.</b> Are you a Troy student athlete? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, which team? _____		<b>17.</b> Are you an international student? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list country of origin: _____	
<b>18.</b> Who referred you to our office?			
<input type="checkbox"/> Self	<input type="checkbox"/> Dean of Student Services		
<input type="checkbox"/> Friend	<input type="checkbox"/> Physician/ Nurse		
<input type="checkbox"/> Parent or relative	<input type="checkbox"/> Faculty/Staff (please provide name): _____		
<input type="checkbox"/> University housing staff	<input type="checkbox"/> Other: _____		
<input type="checkbox"/> Coach or athletic team staff member			
Do we have permission to acknowledge the referral? <input type="checkbox"/> Yes <input type="checkbox"/> No   If yes, please sign below: _____			
<i>(This permission allows us to reveal that you followed up on the referral with this appointment.)</i>			

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

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

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

21. 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? \_\_\_\_\_

22. 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? \_\_\_\_\_

23. Have you ever been hospitalized for a mental health issue? Yes: \_\_\_\_\_ No: \_\_\_\_\_ If you checked yes, please answer the following:

What were you hospitalized for? \_\_\_\_\_

Where were you hospitalized? \_\_\_\_\_

How long were you hospitalized? \_\_\_\_\_

**PERSONAL COUNSELING IS CONFIDENTIAL. HOWEVER, INFORMATION 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** \_\_\_\_\_

**Statement of Non-Discrimination:** Troy University does not discriminate on the basis of sex, age, color, race, national origin, religion, or handicap in its admissions, education, employment, or access to its programs. Troy University complies with the Civil Rights Act of 1964 as amended; Federal Executive Order 11246; Educational Amendments of 1972 and 1974; the Vietnam Era Veterans Readjustment Assistance Act of 1972; Age Discrimination Act of 1975; and Family Educational Rights and Privacy Act of 1974.