Counseling Service Personal Information Form (2012-2013)

The following information will help us serve you better. This information will be kept confidential.

Name _____ Date _____ LC ID # _____

Campus res. hall & room number *or* local street address: _____ MSC Box: ____
May we send any necessary correspondence to this address? Yes ___ No ___

Land line or cell phone(s) at which we may contact you: _____
Is it OK for us to leave you a phone message? Yes ___ No ___

In case of medical emergency, whom may we contact?_____
Phone: _____ Relationship: _____

Check below your reasons for wanting to see a counselor (mark all that apply):
(1) _____ I have some personal feelings/problems I'd like to discuss. (B)
(2) _____ I would like to discuss my courses, grades, study skills, or academic progress. (C)
(3) _____ I would like to discuss my career plans, interests, aptitudes, or abilities. (D)

How much are your counseling concerns hurting your schoolwork? (Circle a number)

Not at all									*Very much*
1	2	3	4	5	6	7	8	9	10

Please indicate below your goals for seeing a counselor:
(1) _____
_____
(2) _____
_____
(3) _____

(F) Sex: Male ___ Female ___ Transgender ____ (G) Age: _____ Date of Birth: _____

(H&I) Please mark **all** that apply:
(1) _____ African American or Black
(2) _____ Asian American or Asian
(3) _____ Mexican American or Chicano
(4) _____ Puerto Rican
(5) _____ Other Latino
(6) _____ White/Caucasian
(7) _____ Native Hawaiian or other Pacific Islander
(8) _____ American Indian or Native Alaskan
(9) _____ International Student from_____
(8) _____ Other Specify: _____

(J) Sexual Orientation
(1) ____Prefer not to answer
(2) ____Bisexual
(3) ____Gay
(4) ____Heterosexual
(5) ____Lesbian
(6) ____Questioning
(7) ____Other

(K) Marital Status
(1) ____Single
(2) ____Partnered
(3) ____Engaged
(4) ____Separated
(5) ____Married
(6) ____Other: _____

(L) How many children do you have? _____ (If none, please put 0)

(M) Are you:
(1) _____ An undergraduate student
(2) _____ A law student
(3) _____ A graduate student (not law school)

(N) **Circle:** First-year Soph. Junior Senior
Indicate year: _____

(O&P) Referred to Counseling Service by:

(1) _____ LC Catalog
(2) _____ Faculty member
(3) _____ Student Financial Service
(4) _____ LC web page
(5) _____ Dean of Students
(6) _____ Campus Living Staff
(7) _____ Student Health Service
(8) _____ Class presentation
(9) _____ Friend
(10) _____ Advisor
(11) _____ Family
(12) _____ Self
(13) _____ Melissa Osmond in Health Promotion & Wellness
(14) _____ Student Support Services
(15) _____ Career & Community Engagement
(16) _____ Pioneer Wellness Card
(17) _____ Other Specify: _____

(Q) Current Major: _____ (R) Advisor's name: _____

(S) Did you transfer to LC? (1) Yes _____ (2) No _____
When? _____ From where? _____

(T) GPA last term: _____ (U) Cumulative GPA: _____

(V) For how many hours are you currently enrolled? _____

(W) Do you have (or suspect you have) a disability (e.g., physical, sensory, learning, ADHD, etc.) that you'd like us to know about? (1) Yes _____ (2) No _____
If yes, please describe: _____

(X) Are you employed? (1) Yes ___ (2) No _____
(Y) If yes, about how many hours per week do you work? _____

Family Data

Person	*Age*	*Occupation*	*Education*	*Marital Status*	*If deceased, how long?*
Father					
Mother					
Step-parent(s)					
Brothers					
Sisters					
Spouse					
Children					

(AB) In my family, there is a history of: (mark all that apply)

___ Alcoholism
___ Abuse of other drugs
___ Depression
___ Bipolar (Manic-Depressive) disorder
___ Eating disorders
___ Emotional abuse
___ Physical abuse
___ Sexual abuse
___ Suicide attempts
___ Completed suicide
___ Schizophrenia

(AC) Are you presently receiving counseling from some other person or agency? (1) Yes ____ (2) No ____
If so, where? _____

(AD) Have you ever had previous counseling? (1) Yes_____ (2) No _____
If so, where? _____
Begin and end dates: _____

(AE) Are you currently taking any prescription medication? (1) Yes _____ (2) No _____
If so, what kind? _____
Who prescribed it for you? _____
What condition is this medication for? _____

Please list current medical conditions: _____

(AF) Have you ever been prescribed medication for any sort of emotional or behavioral difficulty?
(1) Yes _____ (2) No _____

(AG) Have you ever been hospitalized for emotional or psychiatric reasons? (1) Yes ____ (2) No ____

(AH) Have you tried harming yourself in the past? (1) Yes _____ (2) No _____

(AI) Have you physically harmed others in the past? (1) Yes _____ (2) No _____

(AJ) How often do you have a drink containing alcohol?
(One standard drink is equivalent to 12 ounces of beer, 5 ounces of wine, or 1.5 ounces of 80-proof spirits.)

___ Never
___ Monthly or less
___ 2-4 times per month
___ 2-3 times per week
___ 4 or more times per week

(AK) How many drinks containing alcohol do you have on a typical day when you are drinking?

___ None
___ One or two
___ Three or four
___ Five or six
___ Seven to nine
___ Ten or more

(AL) Please indicate which of the following have resulted from your use of alcohol/drugs in the last year:

___ Injury to yourself
___ DUI/DWI violation
___ College disciplinary action
___ Academic problems (e.g., missing class, problems studying)
___ Injury to someone else
___ Blackouts
___ Arguments or conflicts with a friend
___ Other legal problem

(AM) How much coffee do you drink on an average day?_____ How many caffeinated energy drinks?_____
What other caffeine do you ingest on a regular basis? _____

Based on an <u>average month</u>, please indicate your frequency of use:

	Daily	*Weekly*	*Monthly*	*Rarely*	*Never*
Marijuana (pot, hash, hash oil)					
Cocaine (crack, rock, freebase)					
Amphetamines (diet pills, speed, meth, crank)					
Nicotine (cigarettes/cigars, smokeless tobacco, etc.)					
Over-the-counter medication (non-prescription)					
Other psychoactive drugs (non-prescription)					

Student Concerns Rating Scale Lewis & Clark Counseling Service

The following items represent some common concerns of college students. How much has each problem been distressing or bothering you? (Circle your answer for each item.)

0= Not at all 1= A little bit 2= Moderately 3=Quite a bit 4= Extremely

1.	Problems being successful academically	0	1	2	3	4
2.	Concern about staying in school	0	1	2	3	4
3.	Feeling lonely, isolated, or not having close friends	0	1	2	3	4
4.	Difficulty getting along with others	0	1	2	3	4
5.	Problems with parenting your children	0	1	2	3	4
6.	Problems with a romantic, dating or sexual relationship	0	1	2	3	4
7.	Family problems	0	1	2	3	4
8.	Financial problems	0	1	2	3	4
9.	Eating, appetite or weight issues	0	1	2	3	4
10.	Concerns about your physical appearance	0	1	2	3	4
11.	Problems paying attention or concentrating	0	1	2	3	4
12.	Feeling anxious, nervous, fearful, worried or panic	0	1	2	3	4
13.	Self-esteem	0	1	2	3	4
14.	Mood swings (highs and lows)	0	1	2	3	4
15.	Feeling sad, depressed, discouraged or hopeless	0	1	2	3	4
16.	Being self-critical or feeling guilty	0	1	2	3	4
17.	Trouble sleeping or sleeping too much	0	1	2	3	4
18.	Self-injurious behavior (e.g., cutting, burning, bruising)	0	1	2	3	4
19.	Thoughts of suicide	0	1	2	3	4
20.	Intentions of suicide	0	1	2	3	4
21.	Feeling irritable or angry	0	1	2	3	4
22.	Thoughts of wanting to hurt someone else	0	1	2	3	4
23.	Hearing voices or seeing things that others don't see	0	1	2	3	4
24.	Internet use or computer gaming	0	1	2	3	4
25.	Use of alcohol, marijuana or other drugs	0	1	2	3	4
26.	Other addiction (e.g., gambling, nicotine, pornography, sex, etc.)	0	1	2	3	4
27.	Physical health problems	0	1	2	3	4
28.	Difficulties with a disability	0	1	2	3	4
29.	Experiencing prejudice, racism, or discrimination	0	1	2	3	4
30.	Concerns about your major or career choice	0	1	2	3	4
31.	Concerns associated with a sexually transmitted disease	0	1	2	3	4
32.	Problems with your living situation	0	1	2	3	4
33.	Being a victim of unwanted sexual activity, sexual abuse or rape	0	1	2	3	4
34.	Being a victim of violence	0	1	2	3	4
35.	Dealing with a loss from death, separation, divorce or moving	0	1	2	3	4
36.	Adjusting to a new culture	0	1	2	3	4
37.	Issues related to pregnancy	0	1	2	3	4
38.	Concerns about your sexuality	0	1	2	3	4
39.	Other (specify): _____	0	1	2	3	4

The information you have provided will help your counselor understand your needs more quickly. Thanks!