Counseling Service—Personal Information Form

Date:_____

Name:_____ Preferred Name:_____
Can your preferred name be updated for all LC Health and Wellness offices? □ Yes □ No

Phone number: _____

May the Counseling Service leave you a voicemail message? □ Yes □ No
Can this phone number be updated for all LC Health and Wellness offices? □ Yes □ No

E-mail:_____**

May we contact you by email for scheduling purposes ONLY?** □ Yes □ No
**E-mail is not a secure form of communication

Who referred you to the Counseling Service? □ Self □ Family □ Friend □ LC Website
□ Student Health Service □ Student Support Services □ Health Promotions □ Campus Living
□ Career Center □ International Student Services □ Financial Aid □ Dean of Students □ Ombuds Office
□ Faculty (please specify) □ Advisor (please specify) □ Other (Please specify)

If asked to specify, please do so here:_____

Do you have the school-sponsored insurance plan? Y/N
If not, who is your carrier?_____

In case of serious medical emergency, who should be notified? _____
Phone _____ Relationship _____

What is your academic status? □ Part-time □ Full-time

What is your class standing?
□ First-year □ Sophomore □ Junior □ Senior □ Graduate student □ Law Student □ Non-degree

Current Major: _____Advisor's name: _____

GPA last term: _____ Cumulative GPA: _____

For how many credits are you currently enrolled? _____

Did you transfer from another campus/institution to this school? □ Yes □ No

Are you the first generation in your family to attend college? □ Yes □ No

Are you an international student? □ Yes □ No

If yes, what is your country of origin? _____

What is your current gender?
□ Female □ Male □ Trans-FTM □ Trans-MTF □ Gender fluid □ Genderqueer □ Non-binary
□ Questioning/unsure □ Prefer not to answer □ Other (please elaborate)

If you would like to, please further describe your gender identity: _____

Preferred pronouns:
□ She/her/hers □ He/him/his □ They/them/their □ Prefer not to answer □ Other (please elaborate)

If you have an alternate preference, please specify:_____

Please describe your racial, cultural, ethnic, or regional identity: _____

What is your sexual orientation?
□ Lesbian/Gay □ Queer □ Heterosexual/Straight □ Bisexual □ Pansexual □ Questioning □ Other (please elaborate) □ Prefer not to answer

If you would like to, please further describe your sexual orientation:

_____

What is your relationship status:
□ Single □ Dating □ Partnered □ Married or Registered domestic partnership □ Separated □ Divorced
□ Widowed □ Other (please elaborate)

If you would like to, please further describe your relationship status:

_____

Do you have (or suspect you have) a disability (e.g., physical, sensory, learning, ADHD, etc.) that you'd like us to know about?
□ Yes, I have a disability and I am registered with Student Support Services
□ Yes, I have a disability, but I am NOT registered with Student Support Services
□ Yes, I suspect I have a disability, but I have not been diagnosed
□ No

If you selected, "Yes" for the previous question, please indicate which category of disability (check all that apply):
□ Attention Deficit/Hyperactivity Disorders
□ Deaf or Hard of Hearing
□ Learning Disorders
□ Mobility Impairment
□ Neurological Disorders
□ Physical/health related Disorders
□ Psychological disorders/condition
□ Visual impairments
□ Other (please specify) _____

Prior to today, have you attended counseling for mental health concerns:
□ Never
□ Prior to Starting college
□ After starting college
□ Both

Have you taken a prescribed medication for mental health concerns:
□ Never
□ Prior to Starting college
□ After starting college
□ Both

Please list ALL current prescription medications and dosages:

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

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-Nine □ Ten or More

How often do you use marijuana (weed, pot, hash, hash oil)?

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

How many caffeinated beverages (including coffee/soda) do you have on an average day? _____

Based on an average month, please indicate your frequency of use:

	Daily	Weekly	Monthly	Rarely	Never
Cocaine (crack, rock, freebase)					
Opiates (heroin, methadone, pain pills)					
Amphetamines (diet pills, speed, meth, crank)					
ADHD medications- unprescribed (Ritalin, Adderall, etc.)					
Other psychoactive drugs (K, mushrooms, molly, etc.)					
Nicotine (cigarettes/cigars, smokeless tobacco, vape, etc.)					
Over-the-counter medication (non-prescription)					

Please indicate which of the following have resulted from your use of alcohol/drugs in the last year:
□ Injury to yourself □ Injury to someone else □ DUI/DWI violation
□ Blackouts □ College Disciplinary Action □ Arguments/conflicts with a friend
□ Other legal problems □ Academic problems (e.g. missed classes, problems studying)

Please indicate your goal(s) for seeing a counselor:

_____

_____

_____

_____

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 <u>how many times</u> and <u>the last time</u> you had each of the following experiences:

Purposely injured yourself without suicidal intent (e.g. cutting, hitting, burning, etc.):

How many times:	The last time:
Never	Never
One time	Within the last 2 weeks
2-10 times	Within the last month
11-20 times	Within the last year
More than 20 times	Within the last 1-5 years
	More than 5 years ago

Been hospitalized for mental health concerns:

How many times:	The last time:
Never	Never
One time	Within the last 2 weeks
2-3 times	Within the last month
4-5 times	Within the last year
More than 5 times	Within the last 1-5 years
	More than 5 years ago

Seriously considered attempting suicide:

How many times:	The last time:
Never	Never
One time	Within the last 2 weeks
2-3 times	Within the last month
4-5 times	Within the last year
More than 5 times	Within the last 1-5 years
	More than 5 years ago

Made a suicide attempt:

How many times:	The last time:
Never	Never
One time	Within the last 2 weeks
2-3 times	Within the last month
4-5 times	Within the last year
More than 5 times	Within the last 1-5 years
	More than 5 years ago

Student Concerns Rating Scale: The following items represent some common concerns of college students. How much has each problem been distressing or bothering you **within the last month**? (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