LC Student Counseling Center — Personal Information Form

Date:_____

Name:_____

Preferred Name or nickname:_____
If you legally changed your name AFTER being admitted to LC, please provide your full legal name above. Due to the protected nature of your electronic health record, changing your legal name with the college Registrar will not reflect in the health record, and we want to update your name immediately!
Do you want us to share this name with the LC Student Health Center? □ Yes □ No

Phone number: _____
May the Counseling Service leave you a voicemail message? □ Yes □ No
Do you want us to share this phone number with the LC Student Health Center? □ Yes □ No

May we contact you by LC email (for scheduling and survey 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 Rights and Responsibilities □ Student Health Center □ Office of Student Accessibility
□ Health Promotions □ Campus Living □ Career Center □ International Student and Scholars
□ Financial Aid Office □ Dean of Students □ Ombuds Office □ Center for Spiritual Life □ Faculty (please specify) □ Advisor (please specify below) □ Other (Please specify below)

If asked to specify, please do so here:_____

Do you have the school-sponsored insurance plan? □ Yes □ No
If not, what is the name of your medical insurance carrier (e.g. Kaiser; Blue Cross/Blue Shield Oregon; Aetna; Moda; OHP Health Share; Cigna)? _____

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

What is your academic status? □ Part-time □ Full-time
How many credits are you taking this semester? _____

What is your class standing?
□ First-year □ Sophomore □ Junior □ Senior □ Graduate student □ Law Student
□ Non-degree □ Academic English Studies (AES)

What is your academic major? _____

What was your GPA last semester? _____ **What is your Cumulative GPA:** _____

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

Are you an LC athlete? □ 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 gender identity?

□ 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: _____

We want to get your pronouns right! Please be sure that you let our staff know what pronouns you use. You can let us know in this form, or inform us in person or over the phone.

Due to our desire to your college academic record separate from your medical record, any gender or pronoun updates that you recorded with the Registrar's Office will <u>not</u> automatically update into our electronic health records system.

Pronouns:

□ She/her/hers □ He/him/his □ They/them/their □ Prefer not to answer □ She/they
□ He/they □ No pronoun □ Other (please elaborate)_____

If you would like to, please describe your racial, cultural, ethnic, or regional identity:

What is your sexual orientation?

□ Lesbian/Gay □ Queer □ Heterosexual/Straight □ Bisexual □ Questioning □ Pansexual
□ Asexual □ Other (please elaborate) _____

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 the Office of Student Accessibility
□ Yes, I have a disability, but I am NOT registered with the Office of Student Accessibility
□ 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/Conditions
□ 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 to 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 of the following:

	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 (check all that apply):

□ Injury to yourself □ Injury to someone else □ DUI/DWI violation
□ Blackouts □ College Disciplinary Action □ Arguments/conflict with a friend
□ Other legal problems □ Academic problems (e.g. missed classes, problems studying) □ None

Please name 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 was:
Never	Never
One time	Within the last month
2-10 times	Within the last year
11-20 times	More than 1 year ago
More than 20 times	

Been hospitalized for mental health concerns:

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

Seriously considered attempting suicide:

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

Made a suicide attempt:

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

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/survivor 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