University of North Texas at Dallas
Counseling & Wellness Services

STUDENT INFORMATION FORM

Please complete all information.

IDENTIFYING INFORMATION

NAME: **TODAY'S DATE:**

STUDENT ID#: **DATE OF BIRTH:** **AGE:**

GENDER: ☐ Female ☐ Male ☐ Transgender ☐ Other (identify) **ETHNICITY:**

SEXUAL ORIENTATION: ☐Bisexual ☐Heterosexual ☐Lesbian/Gay ☐Queer ☐Questioning ☐Other (identify)

RELATIONSHIP STATUS: ☐Single ☐Partnered ☐Married ☐Separated ☐Divorced ☐Widowed ☐Other (identify)

CONTACT INFORMATION:

Address: ____ City: __________________________ State: _________ Zip Code: _____________

Cell Phone #: ____ ☐ OK to phone ☐ OK to leave message

Home or Other phone #: ___________________________________ ☐ OK to phone ☐ OK to leave message

UNT E-mail address: ____ (please be aware that email may not be confidential)

☐OK to email you regarding your appointment. ☐OK to email you an evaluation survey regarding your experience.

PREFERRED METHOD OF CONTACT: ☐Cell Phone ☐Home/Other Phone ☐Email ☐Mail ☐Other (identify) ______________________

EMERGENCY CONTACT:

Name: ____ Relationship: __________________________ Phone: __________________________________

Address: ____ City: __________________________ State: _________ Zip Code: ______________

ACADEMIC STATUS: ☐Freshman ☐Sophomore ☐Junior ☐Senior ☐Graduate Student ☐Other (identify) _________________________

ACADEMIC INFORMATION:

Major/Academic Department: ____ Course load this semester: __________________________

High School GPA: Transfer GPA (if applicable): UNT Dallas GPA:

EMPLOYMENT INFORMATION: ☐Not Employed ☐On-Campus Employment ☐Off-Campus Employment

Employer: ________________________________ Hours Worked Per Week: _______________

REFERRED BY: ☐Self ☐Professor ☐Dean ☐Advisor ☐Medical Provider ☐Parent ☐Friend ☐Other (identify) _______________

If SELF, How did you hear about our services?

HEALTH INSURANCE COVERAGE: ☐ Student Health Insurance ☐ Private Insurance (specify name of insurance plan)

OTHER INFORMATION: (check YES for those groups that apply to you and answer the corresponding follow-up questions)

VETERAN ☐ NO ☐ YES – Branch of Military______________________________________ Time of Service: __________________________________

INTERNATIONAL STUDENT ☐ NO ☐ YES – Country____

TRANSFER STUDENT ☐ NO ☐ YES – Transfer From ____

STUDENT WITH DISABILITIES ☐ NO ☐ YES – Diagnosis: ____

If YES, Are you registered with Disability Services: ☐ Yes ☐ No

FIRST GENERATION COLLEGE STUDENT (excluding siblings): ☐ NO ☐ YES

HAVE YOU EVER BEEN IN ANY CATEGORY OF ACADEMIC DIFFICULTY WHILE AT UNT Dallas? ☐ NO ☐ YES

If YES, Check if applicable: ☐ Academic Probation ☐ Subject to Dismissal ☐ Conduct Problem ☐ Other:

PRESENTING CONCERNS

Briefly describe what brings you to Counseling & Wellness Services for counseling? ____

____

Approximately how long has this been bothering you? ☐Day ☐Week ☐Month ☐Several Months ☐Year ☐Several Years ☐Always

Please CHECK ALL ITEMS CURRENTLY APPLY.

☐ Academic concerns
☐ Addictions
☐ ADHD/learning problems
☐ Adjustment to college
☐ Adjustment to new experiences
☐ Alcohol/drug concerns
☐ Anger management
☐ Anxiety, fear, nervousness
☐ Career/job concerns
☐ Compulsive behavior
☐ Concentration difficulties
☐ Concern with other's well-being
☐ Cultural/multicultural concerns
☐ Cutting or self-injury
☐ Depression, sadness
☐ Discrimination
☐ Eating concerns/body image
☐ Emotional/psychological abuse
☐ Episodes of manic behavior
☐ Faculty/advisor concerns
☐ Family problems
☐ Feeling doomed/helpless
☐ Financial concerns
☐ Graduation preoccupations
☐ Harassment
☐ Identity/sense of self
☐ Impulse control
☐ Internet/video game concerns
☐ Intimate relationship concerns
☐ Interpersonal concerns
☐ Legal concerns
☐ Loneliness
☐ Loss, grief, death
☐ Self-esteem
☐ Medical/health concerns
☐ Mood swings
☐ Obsessive thoughts
☐ Panic attacks
☐ Paranoia
☐ Phobias
☐ Physical abuse/assault
☐ Procrastination
☐ Racing thoughts
☐ Relationship concerns
☐ Sexual abuse/sexual assault
☐ Sexuality concerns
☐ Sleep difficulties
☐ Spiritual/religious concerns
☐ Stress or tension
☐ Thoughts of suicide
☐ Trouble making decisions
☐ ______________________________
☐ ______________________________

How much do your concerns interfere with…

Academic Performance Low ←--1—2—3—4—5--→ Severe

Emotional Well-being Low ←--1—2—3—4—5--→ Severe

Social Relationships/ Activities Low ←--1—2—3—4—5--→ Severe

Daily Routine Low ←--1—2—3—4—5--→ Severe

Due to the impact of your concerns on your Academic Performance, are you considering: ☐Withdrawal ☐Dropping Out ☐Transferring

MENTAL HEALTH HISTORY

Are you CURRENTLY receiving professional counseling or psychotherapy elsewhere? ☐ YES ☐ NO

If YES, please specify: **Provider:** **Contact #:**

Have you received counseling/psychotherapy in the PAST? ☐ YES ☐ NO

If YES, please specify: **Provider:** **Reason:** **When:**

Are you CURRENTLY taking prescribed psychiatric medications? ☐ YES ☐ NO

If YES, please specify medications and dosages:____

Have you been prescribed psychiatric medication in the PAST? ☐ YES ☐ NO

If YES, please specify medications, dose, and dates taken:____

Have you been hospitalized for PSYCHIATRIC reasons? ☐ YES ☐ NO

If YES, please specify dates, facility, and reasons for hospitalization: ____

Have you ever had thoughts of harming yourself? ☐ YES ☐ NO

If YES, please describe:

Have you ever purposefully injured yourself without suicidal intent? (e.g. cutting, hitting, burning, etc.) ☐ YES ☐ NO

If YES, please describe:

In the LAST FEW DAYS, have you had suicidal thoughts? ☐ YES ☐ NO

If YES, please answer the following:

FREQUENCY:	DURATION:	INTENSITY:
☐ Rarely	☐ Seconds	☐ Brief and fleeting
☐ Sometimes	☐ Minutes	☐ Focused
☐ Frequently	☐ Always	☐ Intense
☐ Always	☐ Constant	

Have you seriously considered attempting suicide in the PAST? ☐ YES ☐ NO

If YES, please describe:____

Have you ever made a suicide attempt? ☐ YES ☐ NO

If YES, please describe:____

Do you CURRENTLY have thoughts of harming another person? ☐ YES ☐ NO

If YES, please describe:

Have you ever intentionally physically harmed someone? ☐ YES ☐ NO

If YES, please describe:

SUBSTANCE USE

Do you REGULARLY use alcohol? ☐ YES ☐ NO

In a typical MONTH, how often do you have 4 OR MORE drinks in a 24-hour period? ☐ Never ☐ Rarely ☐ Monthly ☐ Weekly ☐ Daily

Do you consider your alcohol consumption a problem? ☐ YES ☐ NO ☐ Not Applicable

Have you used any drug in the past 90 days that was not prescribed by a doctor? (e.g., marijuana, meth, cocaine, diet pills, ecstasy, Xanax, valium, ADHD meds, LSD, acid, mushrooms, heroin, pain killers, or other)? ☐ YES ☐ NO

If YES, indicate which substances and when. ____

How often do you engage in recreation drug use? ☐ Never ☐ Rarely ☐ Monthly ☐ Weekly ☐ Daily

Do you consider your drug use a problem? ☐ YES ☐ NO

Have you ever received treatment for alcohol or drug use? ☐ YES ☐ NO

If yes, indicate when, where, and length of treatment. ____

Was this treatment helpful? ☐ YES ☐ NO

What is your typical DAILY CAFFEINE use? ☐ None/Infrequent ☐ 1-2servings ☐ 3-5 servings ☐ 5+ servings

What is your typical DAILY NICOTINE use? ☐ None/Infrequent ☐ Less than 5 cigarettes ☐ 5-20 ☐ 20+ ☐ Other Use

HEALTH & SOCIAL HISTORY

When was your last physical exam?

How is your physical health at the present time? ☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Excellent

Have you had any serious accidents, injuries, or illnesses? ☐ NO ☐ YES, please describe:

Are you presently taking any medications for a physical health condition? ☐ NO ☐ YES, please describe:

Please list any PERSISTENT PHYSICAL SYMPTOMS or health concerns: (e.g., chronic pain, headaches, hypertension, diabetes, etc.) ___________________

Are you having any problems with sleep habits? ☐ NO ☐ YES, please describe:

How many times a week do you exercise? **For about how long each time?**

Are you having any difficulty with appetite or eating habits or weight change? ☐ NO ☐ YES, please describe:

Do you have any problems or worries about sexual functioning? ☐ NO ☐ YES, please describe:

Besides family members, approximately how many people can you really count on right now for friendship and emotional support?

Are you CURRENTLY in a significant intimate relationship? ☐ NO ☐ YES

How many significant intimate relationships (last 6 months or more) have you had in the past 5 years?

FAMILY & CULTURAL BACKGROUND

Mother's Age: **Father's Age:**

If deceased, indicate YOUR AGE when she died: **If deceased, indicate YOUR AGE when he died:**

Mother's Occupation: **Father's Occupation:**

Parent's marital status: ☐Partnered ☐Married ☐Separated ☐Divorced ☐Widowed ☐Other (identify)

Please list the members of your family, including ages and occupations (e.g., "Brother, 22, student")

Were you and both of your parents born in the USA? ☐ YES ☐ NO

If NO, please indicate who was foreign-born, where, and the approximate age of immigration to the US ____

Does your family speak a language other than English at home? ☐ YES ☐ NO If YES, please indicate which language:

What is your ethnic identity?

Religious Preference: **Are you currently active in your religion?** ☐ YES ☐ NO

How much is your immediate family a source of support for you?

Have you personally experienced LEGAL PROBLEMS? ☐ YES ☐ NO

Have you personally experienced LEARNING PROBLEMS? ☐ YES ☐ NO

Do you have children? ☐ YES ☐ NO If yes, indicate the age and gender of each child:

GOALS

What do you consider your main STRENGTHS?____

What are your life AMBITIONS and GOALS? ____

What would you like to CHANGE about yourself? ____

What do you hope to get out of counseling?____

Please tell us any additional information that you think would be helpful in working with you. ____