Capital University
Ask. Think. Lead.

Counseling Services Information Form

Capital University Law School

Demographic Information

_____ _____ _____ _____ _____
Today's Date *Name (first, middle, last)* *Gender* *Date of Birth* *Age*

_____
Local Address *City* *State* *Zip*

_____ _____
Primary Phone *May we call you at this number? (Y/N)* *Work Phone* *May we call you at this number? (Y/N)*

_____
Email Address *May we email you? (Y/N)*

_____ _____ _____
Emergency Contact Name *Relationship* *Phone*

International Students/Dual Citizens: _____ _____
Citizenship and Country of Origin *Yrs in USA*

Campus: ___Bexley ___Law School **Class Year**:_____ **Major/Program of Study:**_____

Are you employed? __Yes __No **If so, where / # hours work per week?**_____

Description of Presenting Problem

Please state why you have decided to pursue counseling: _____
_____
_____

Did anyone refer or recommend you to counseling? ___Yes ___No **If so, who?**_____

What do you want to work on or change through counseling? _____
_____
_____

How would you estimate the severity of the problem at this time? (Place an "X" on the line below)

Mild ***Moderate*** ***Serious*** ***Severe***

How long has this been a significant problem for you? Please be specific. _____
_____

Have you had any suicide attempts? ___Yes ___No

Have you ever had treatment by, or are you currently seeing, a psychiatrist, psychologist, therapist, or counselor? ___Yes ___No
If yes, please note the following:

_____
Presenting Problem *Location (city/state)* *When (dates)* *Was it helpful? (Y/N)*

_____
Presenting Problem *Location (city/state)* *When (dates)* *Was it helpful? (Y/N)*

What concerns/symptoms contributed to you coming in today? *Please check all that apply.*

__academic concerns
__adjustment to the university
__alcohol and/or drugs
__anxiety/worry
__blackouts/memory loss
__career concerns
__concerns about major/program of study
__compulsive behaviors
__depressed mood
__difficulty concentrating
__difficulty making friends
__distrust
__easily distracted
__experienced a traumatic event
__experiencing discrimination
__fatigue/loss of energy
__feeling manipulated or controlled
__feelings of worthlessness
__fear of specific places/objects
__financial concerns
__gay/lesbian/bisexual/transgender concerns
__hearing voices
__homesickness
__housing concerns
__inability to control thoughts
__irritable, angry, hostile feelings
__issues with food/weight/appetite
__loneliness
__loss of significant person
__nightmares
__numbness/lack of emotion
__obsessions
__parental alcohol/drug abuse
__physical symptoms (headaches, stomach pains, rapid heartbeat, dizziness, muscle tension, etc.)
__procrastination/lack of motivation
__racial/ethnic identity
__relationship with a friend/roommate
__relationship with romantic partner
__relationship with parents/family
__self-esteem, self-confidence
__self-harm behaviors (cutting, burning, etc.)
__sexual concerns (pain during intercourse, erectile dysfunction, libido, etc.)
__shyness/being assertive
__sleep difficulties
__specific issues to discuss only with counselor
__spiritual/religious concerns
__stressed/under pressure
__suicidal feelings/behavior
__test anxiety or speech anxiety
__withdrawing from friends/ family/social activities
__other_____

In the past, what has been helpful to you in dealing with these concerns/symptoms? _____
_____

Would you be willing to allow a counseling intern to sit-in and observe your intake session today? __Yes __No __Unsure
The Center for Health and Wellness serves as a practicum/internship site for graduate level counseling students. Our counseling student is licensed by Ohio's Counselor, Social Worker, and Marriage & Family Therapist Board as a Counselor Trainee, and is pursuing the University of Dayton's master's degree program in community counseling. Our student is undergoing supervision by CHW licensed counseling staff and a UD faculty member. No confidential identifying information will be shared outside of the CHW.

Medical Information

Date of your last physical exam: _____ Please list any significant past or current health, medical, or psychiatric issues (including anything resulting in hospitalizations):

_____
Dates *Problem & Treatment* *Were you hospitalized? (Y/N)*

_____
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_____
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Have you ever experienced: *(please mark all that apply)* __Emotional Abuse __Physical Abuse __Sexual Abuse __Sexual Assault

Medications & Supplements

If applicable, please list all medications you are now taking or have taken in the past three months, including birth control, pills, vitamins, herbs and supplements:

Medication	Dosage	Prescribing Physician	How long have you been taking this?	Helpful? (Y/N)

If applicable, amount of caffeinated beverages per day: __coffee ___soda ___espresso ___tea ___energy drink

Do you use tobacco products? ___Yes ___No **If so, what type(s)?**_____

If applicable, number of alcoholic beverages consumed each week:_____

If you have used/currently use inhalants ("huffing"), such as glue, gasoline, or paint thinner, please list the type, the last time you used, and the frequency of use:_____

If you have used/currently use any street/illicit drugs (not medications prescribed to you), please list the type, the last time you used, and the frequency of use:_____

Have you ever felt the need to cut down on your drinking and/or drug use? ___Yes ___No

Has anyone ever expressed concern about your alcohol and/or drug use? ___Yes ___No

If so, have you found those questions annoying or intrusive? ___Yes ___No

Do you use alcohol and/or drugs to *(check all that apply)*: __Manage stress __To relax __To change mood __For sleep

Family/Household/Relationship Information

Please list the names of all immediate family members, noting their relation to you, age, and living arrangement.

Name	Relation	Age	Lives with you? (Y/N)

Have any members of your family had problems with: ___Drugs ___Alcohol ___Depression ___Anxiety ___Other mental illness

Among friends and family, whom do you count on for support? _____

Sexual Orientation: __Heterosexual __Gay __Lesbian __Questioning __Queer __Bisexual __Other_____

Are you: __Single __Dating __Partnered __Married __Divorced __Widowed __Other_____

If applicable, please describe your current relationship by placing an "X" on the line below:

No problems *Minor concerns* *Moderate concerns* *Serious concerns*

How long have you been in the relationship? _____

If there is anything else you would like us to know that will help us best assist you, please describe below: