

If you are a returning client, is there any change in your information? No Change ___ Updated ___

Therapist: _____ Brochure: _____ Date of Appointment: _____

Name: _____ Gender: _____ Student ID # _____

Birthdate: ____-____-____ Age ____ International Student: Yes ___ Country: _____
(M) (D) (Y)

Current University or local address if applicable: _____

Dorm/Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____ CPU Box: _____

We may need to contact you regarding an appointment. **Please Note: Email and cell phones should NOT be considered a secure or confidential means of communication. This should be taken into account when communicating by email or cell phones. My initials below indicate my consent to contact me by:**

Home Phone: _____ Work Phone: _____ Cell Phone: _____ Email: _____ Can we leave a voice mail message? _____

School/College _____ Department _____ Class Year _____

Please check all that apply: _____ Full-time _____ Undergraduate _____ Medical Student _____ Transfer, if yes,
_____ Part-time _____ Graduate Student _____ Other _____ When _____

Partner's name (if applicable) _____

Past and Current Medical Concerns (include medical conditions, allergies, hospitalizations, surgeries, etc.) _____

_____ If you are having current or recent physical pain, on a scale of 0-10, (0 = no pain), how much physical pain are you feeling today?
If you are in treatment for this pain, please specify with whom. _____

Current Medication(s) and Dosage _____

Current Primary Care Physician _____

Have you been seen in counseling/therapy before? Yes ___ No ___ At UCC? ___ Other? _____

Previous therapist(s) or treatment facility(s) _____

Were you referred to UCC? Yes ___ No ___ If yes, by whom? _____

Complete for all members of your family, **including yourself**. Circle your own rank among the siblings (1st, 2nd, 3rd, etc.).

	Relationship	Marital Status	Living or Deceased	Age	Sex	Occupation	Education
Family of Origin	Parent 1						
	Parent 2						
	Parent 3						
	Parent 4						
	1st Sibling						
	2nd Sibling						
	3rd Sibling						
	4th Sibling						
	5th Sibling						
Current Family	Spouse/ Partner						
	1st Child						
	2nd Child						

Emergency contact: (name) _____ (relationship) _____

Phone Number:(_____) _____ Address, City, State and Zip: _____

Never
Rarely
Sometimes
Frequently
Almost Always

INSTRUCTIONS: Looking back over the last week, including today, help us understand how you have been feeling. Read each item carefully and circle the number which best describes your current situation. Circle only one number for each question and do not skip any. If you want to change an answer, please “x” it out and circle the correct one.

- | | | | | | |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 1. I get along well with others. |
| 0 | 1 | 2 | 3 | 4 | 2. I tire quickly. |
| 0 | 1 | 2 | 3 | 4 | 3. I feel no interest in things. |
| 0 | 1 | 2 | 3 | 4 | 4. I feel stressed at work/school. |
| 0 | 1 | 2 | 3 | 4 | 5. I blame myself for things. |
| 0 | 1 | 2 | 3 | 4 | 6. I feel irritated. |
| 0 | 1 | 2 | 3 | 4 | 7. I feel unhappy in my marriage/significant relationship. |
| 0 | 1 | 2 | 3 | 4 | 8. I have thoughts of ending my life. |
| 0 | 1 | 2 | 3 | 4 | 9. I feel weak. |
| 0 | 1 | 2 | 3 | 4 | 10. I feel fearful. |
| 0 | 1 | 2 | 3 | 4 | 11. After heavy drinking, I need a drink the next morning to get going (If you do not drink, mark “never”). |
| 0 | 1 | 2 | 3 | 4 | 12. I find my work/school satisfying. |
| 0 | 1 | 2 | 3 | 4 | 13. I am a happy person. |
| 0 | 1 | 2 | 3 | 4 | 14. I work/study too much. |
| 0 | 1 | 2 | 3 | 4 | 15. I feel worthless. |
| 0 | 1 | 2 | 3 | 4 | 16. I am concerned about family troubles. |
| 0 | 1 | 2 | 3 | 4 | 17. I have an unfulfilling sex life. |
| 0 | 1 | 2 | 3 | 4 | 18. I feel lonely. |
| 0 | 1 | 2 | 3 | 4 | 19. I have frequent arguments. |
| 0 | 1 | 2 | 3 | 4 | 20. I feel loved and wanted. |
| 0 | 1 | 2 | 3 | 4 | 21. I enjoy my spare time. |
| 0 | 1 | 2 | 3 | 4 | 22. I have difficulty concentrating. |
| 0 | 1 | 2 | 3 | 4 | 23. I feel hopeless about the future. |
| 0 | 1 | 2 | 3 | 4 | 24. I like myself. |
| 0 | 1 | 2 | 3 | 4 | 25. Disturbing thoughts come into my mind that I cannot get rid of. |
| 0 | 1 | 2 | 3 | 4 | 26. I feel annoyed by people who criticize my drinking (or drug use) (if not applicable, mark “never”). |
| 0 | 1 | 2 | 3 | 4 | 27. I have an upset stomach. |
| 0 | 1 | 2 | 3 | 4 | 28. I am not working/studying as well as I used to. |
| 0 | 1 | 2 | 3 | 4 | 29. My heart pounds too much. |
| 0 | 1 | 2 | 3 | 4 | 30. I have trouble getting along with friends and close acquaintances. |
| 0 | 1 | 2 | 3 | 4 | 31. I am satisfied with my life. |
| 0 | 1 | 2 | 3 | 4 | 32. I have trouble at work/school because of my drinking or drug use (if not applicable, mark “never”). |
| 0 | 1 | 2 | 3 | 4 | 33. I feel that something bad is going to happen. |
| 0 | 1 | 2 | 3 | 4 | 34. I have sore muscles. |
| 0 | 1 | 2 | 3 | 4 | 35. I feel afraid of open spaces, of driving, or being on buses, subways, and so forth. |
| 0 | 1 | 2 | 3 | 4 | 36. I feel nervous. |
| 0 | 1 | 2 | 3 | 4 | 37. I feel my love relationships are full and complete. |
| 0 | 1 | 2 | 3 | 4 | 38. I feel that I am not doing well at work/school. |
| 0 | 1 | 2 | 3 | 4 | 39. I have too many disagreements at work/school. |
| 0 | 1 | 2 | 3 | 4 | 40. I feel something is wrong with my mind. |
| 0 | 1 | 2 | 3 | 4 | 41. I have trouble falling asleep or staying asleep. |
| 0 | 1 | 2 | 3 | 4 | 42. I feel blue. |
| 0 | 1 | 2 | 3 | 4 | 43. I am satisfied with my relationships with others. |
| 0 | 1 | 2 | 3 | 4 | 44. I feel angry enough at work/school to do something I might regret. |
| 0 | 1 | 2 | 3 | 4 | 45. I have headaches. |

Have you ever intentionally cut or otherwise hurt yourself? Yes No (please circle) If yes, explain.

Have you ever attempted suicide? Yes No (please circle) If yes, explain.

During the past year, what kind of stresses have you had?

Briefly explain your reasons for coming in today including any other information you would like your therapist to know about you.

Optional Information: How would you describe yourself? Please place an “x” by the correct description:

- | | |
|--|---|
| <input type="checkbox"/> White or Caucasian | <input type="checkbox"/> Asian American |
| <input type="checkbox"/> Hispanic, Latino | <input type="checkbox"/> Mexican American, Chicano |
| <input type="checkbox"/> Native American, Alaskan Native | <input type="checkbox"/> Native Hawaiian, Pacific Islander |
| <input type="checkbox"/> African American, Black | <input type="checkbox"/> Puerto Rican |
| <input type="checkbox"/> Asian (Including Indian Subcontinent) | <input type="checkbox"/> Multi-ethnic – please place an “x” by all that apply above |