The following information will help us in serving you better. All information you share will be treated as **CONFIDENTIAL.**

UCM Counseling Center *Initial Consultation Form*	***Date:***
	Banner ID #:

First Name:	***Middle:***	***Last:***

Preferred Name: Preferred Pronoun: ***Date of Birth***: _____ /_____ /_____

Phone #: Lv. Msg? ☐ Yes ☐No	***Other Phone #:*** Lv. Msg? ☐ Yes ☐No

Permanent Address: Ok to send mail? ☐ Yes ☐No
City/State/Zip:

Local Mailing Address: Ok to send mail? ☐ Yes ☐No
City/State/Zip:

Enter your email if you allow us to communicate with you by email. (e.g. appointment reminders):

Emergency Contact:	***Relationship:***
Emergency Contact Address:	***Phone #:***

Race / Ethnicity:

☐African American/Black ☐American Indian/Alaskan native ☐ Asian American/Asian
☐ White ☐ Hispanic/Latino/a ☐ Native Hawaiian/Pacific Islander
☐ Multi-racial ☐Self-Identify: _____

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

Religious or spiritual preference?

☐Agnostic ☐Catholic ☐Jewish ☐ Self-Identify:_____
☐Atheist ☐Christian ☐ Muslim
☐ Buddhist ☐ Hindu ☐ No preference

Country of origin:	***International Student***? ☐ Y ☐N

What is your gender identity?	***What was your sex at birth***?
☐Woman	☐Female
☐Man	☐Male
☐Transgender	☐Intersex
☐Self-Identify:_____	

Relationship Status:

☐ Single
☐ Serious dating/Committed relationship
☐ Civil union / domestic partnership or equivalent
☐ Married
☐ Separated
☐ Divorced
☐ Widowed

People are different in their sexual attraction to other people. Which best describes your current feelings?

☐ Only attracted to women
☐ Mostly attracted to women
☐ Equally attracted to women and men
☐ Mostly attracted to men
☐ Only attracted to men
☐ Don't experience sexual attraction
☐ Not sure
☐ Self-Identify:_____

Do you consider yourself:

☐ Heterosexual/Straight
☐ Lesbian
☐ Gay
☐ Bisexual
☐ Questioning
☐ Self-Identify:
_____

Current Academic Status:

☐ Freshman/First year
☐ Sophomore
☐ Junior
☐ Senior
☐ Faculty/Staff
☐ Non-student
☐ Graduate/professional degree student
☐ High school student taking college classes
☐ Non-degree student
☐ Other, specify:_____

Major:

GPA:

Are you registered with the office for disability services on this campus as having a documented and diagnosed disability? ☐ Yes ☐ No

If you selected "Yes" for the previous question, please indicate which category of disability you are registered for (check all that apply):

☐ Difficulty hearing
☐ Difficulty seeing
☐ Difficulty speaking/language impairment
☐ Mobility limitation/orthopedic impairment
☐ Traumatic brain injury
☐ Specific learning disabilities
☐ ADD or ADHD
☐ Autism Spectrum disorders
☐ Cognitive difficulties or intellectual disability
☐ Health impairment/condition, including chronic conditions
☐ Psychological/psychiatric condition
☐ Other, specify: _____

What kind of housing do you currently have? ☐On-campus residence hall/apartment ☐On/off campus fraternity/sorority house ☐ On/off campus co-operative house ☐ Off-campus apartment/house ☐ Other, specify: _____	***With whom do you live?*** (check all that apply) ☐Alone ☐Spouse, partner, or significant other ☐Roommate(s) ☐ Children ☐ Parent(s) or guardian(s) ☐ Family, other ☐ Other, specify: _____

Are you the first generation in your family to attend college? ☐ Y ☐N

Have you ever served in any branch of the US military (active duty, Veteran, National Guard or reserves? ☐ Y ☐N

Have you been, are you currently, or do you anticipate being involved in any legal matters? ☐ Y ☐N

Ever used any of these weight control measures?
☐Vomiting
☐Laxatives / Diuretics
☐Excessive Exercise
☐ Not Eating
☐ Diet Pills

Think back over the past 2 weeks, how many times have you had:
For males: *5 or more drinks* in a row?* ***For females:*** *4 or more drinks* in a row?*
*(*a drink is a bottle of beer, a glass of wine, a wine cooler, a shot of liquor, or a mixed drink.)*

☐ None ☐ Once ☐ Twice ☐ 3-5 times ☐6-9 times ☐ 10 or more times

Think back over the past 2 weeks, how many times have you used marijuana:

☐ None ☐ Once ☐ Twice ☐ 3-5 times ☐6-9 times ☐ 10 or more times

Please indicate if/when you have had the following experiences: Check one per row →	Never	Prior to college	After starting college	Both
Attended counseling from mental health concerns: If so, when and for how long? _____				
Taken a prescribed medication for mental health concerns				

BOTH parts of each questions should be answered. i.e. How many times? AND The last time?											
	How many times?					***Last time it happened?***					
Select one for each question →	Never	Once	2-3	4-5	More than 5	Never	Less than 2 weeks	Less than 1 month	Less than 1 year	Less than 5 years	More than 5 years
Been hospitalized for mental health concerns											
Felt the need to reduce your alcohol or drug use											
Others have expressed concern about your alcohol or drug use											
Received treatment for alcohol or drug use											
Purposely injured yourself without suicidal intent (e.g., cutting, hitting, burning, etc.)											
Seriously considered attempting suicide											
Made a suicide attempt											
Considered causing serious physical injury to another person											
Intentionally caused serious physical injury to another											
Someone had sexual contact with you without your consent (e.g., you were afraid to stop what was happening, passed out, drugged, drunk, incapacitated, asleep, threatened or physically forced)											
Experienced harassing, controlling, and/or abusive behavior from another person (e.g., friend, family member, partner, or authority figure)											
Experienced a traumatic event that caused you to feel intense fear, helplessness, or horror											
Is the experience of trauma part of why you came to the Counseling Center? ☐ Y ☐N											
Is discrimination part of why you came to the Counseling Center? ☐ Y ☐N											

Please describe any recent losses (e.g. job change, divorce, death, relationship change, or other difficult changes)

MAIN CONCERNS: List the concerns you would like help with.

Concern A: _____

Concern B:_____

Concern C:_____

BRIEFLY describe why you are seeking help NOW:_____

Self-assessment of functioning: Please rate from 0 to 10 how well you are currently functioning in the following areas.
"0" means not functioning and "10" means excellent functioning

Academics

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Socially

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Physically

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Please rate your mood on a scale of 0 to 10, with 0 meaning "very low mood" and 10 being "I feel great"

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Please describe any medical conditions you have:

Please list any psychiatric or other prescription medications you are taking:

FAMILY HISTORY:

Please list parents and their occupations: _____

Please list siblings and their ages: _____

_____

Do you have children? ☐Y ☐N **Your Children's ages:** _____

University of Central Missouri
Counseling Center
Client Information Form

CCMH Consent

The Counseling Center participates in a national research project designed to improve our services and expand the knowledge about college student mental health. We participate by contributing anonymous, numeric data provided by those who use our services (and are over 18 years old) to a database managed by researchers at Penn State University. Data is stripped of all personally identifying information and then combined with anonymous, numeric data from other colleges nationwide for statistical analysis. Because data cannot be linked to specific individuals, there are virtually no risks contributing data. With your permission, we would like to contribute anonymous, numeric data from the questionnaires you just completed. Your decision is voluntary and will not affect the services you receive. If you have questions or concerns, you may contact the Director of the Counseling Center.

Will you allow your anonymous, numeric responses to be contributed?

○ Yes ○ No