Arkansas Tech University Health and Wellness Center

CONFIDENTIAL INFORMATION SHEET

DATE: _____ T#_____ Counselor: _____

NAME _____(_____)
Last First M. Preferred/Nickname (if applicable)

Tech Email_____

Local Address/Residence Hall and Room# _____

City _____ State_____Zip_____

Cell Phone _____ Ok to call this #? Y____N____

Email _____

Gender: _____Age: _____ Date of Birth: _____

Race/Ethnic Background: African-American / Black ____ American Indian or Alaskan Native ____ Asian American / Asian ___ Caucasian / White ___ Hispanic / Latino/a ____ Native Hawaiian or Pacific Islander ____ Multi Racial ____ Prefer not to answer ____ Self-identify (please specify): _____

Sexual Orientation: Bisexual ___ Heterosexual ___ Lesbian/Gay ___ Questioning ___
Self-identify (please specify): _____
Preferred Pronouns: _____

Relationship Status: Single ___ Married ___ Divorced ____ Engaged ____ Dating ____ Living Together ____ Separated ____ Widowed ____ Self-identify (please specify):_____

Children: Yes _____ No_____ How Many _____ Ages: _____

Military: Active ____ Reserves ____ Branch: Air Force ____ Army ____ Navy ____ Marines ____ Coast Guard ____
Veteran: Yes ____ No ____ Military Dependent: Yes ____ No ____

Classifications: Freshman ___ Sophomore ___ Junior ___ Senior ___ Graduate Student ___

Major: _____Current GPA:_____

Are you currently employed? Yes ____ No ____ Average number of hours per week:_____

Housing situation: On campus___ With family ____ With partner ____ With others ____

Who referred you to counseling? CARE Team ____ Dean of Students ____ Self ____ Faculty/Staff ____ Family____
Student Health Clinic ____ Friend ____ Partner/Spouse ____ Physician ____ Roommate ____ Other ____
Did you take the Mental Health Online Screening? Yes ____ No ____

Previous counseling help? Yes _____ No _____
If yes, name of counselor and/or facility:_____

Are you presently taking any medication? Yes _____ No _____
Prescription: _____
Prescribed by: Family Doctor ___ Psychiatrist ___ OB/GYN ___ Student Health Clinic ___ Over the counter ___
Reason: _____

How often do you drink alcohol? ___0x/wk___1-2x/wk___3 or more x/wk
Average amount consumed_____
Negative consequences of using _____
How often do you use other drugs? ___0x/wk___1-2x/wk___3 or more x/wk
Average amount consumed_____
Negative consequences of using_____

Names of family members (Parents and Siblings) / Significant Others (Partner and Children):
_____

_____

_____

In your own words, please describe your relationship with family/significant other/friends:
_____

_____

_____

_____

_____

_____

Please state, in your own words, what you would like to discuss with the counselor?
_____

_____

_____

_____

_____

Emergency Contact Person _____ Relationship _____ Phone _____

How serious do you consider your present concerns: ___Not at all ___Mildly ___Moderately ___Highly
How motivated are you to resolve your concerns: ___Not at all ___Mildly ___Moderately ___Highly
How optimistic are you that your concerns can be resolved: ___Not at all ___Mildly ___Moderately ___Highly

How long have the problems persisted:
_____

_____

Counseling Services offers groups each semester which are opportunities to share common concerns with other students. Would you like to be included on a listserv to receive information about groups? _____ Yes _____ No

What are your goals for counseling (i.e., what do you want to occur as a result of counseling)? Please be as specific as possible.

1. _____

2. _____

3. _____

Is there anything else you would like your counselor to know about you?

_____

_____

_____

_____

_____

The Well-Being Scale

Please rate your current well-being on the scales below with 1 indicating low levels of well-being and 10 indicating high levels of well-being.

How well are you doing individually (mood, thoughts, motivation, etc.)?

1 2 3 4 5 6 7 8 9 10

How well are you doing in your relationships with others (friendships, family, romantic, etc.)?

1 2 3 4 5 6 7 8 9 10

How well are you doing in school?

1 2 3 4 5 6 7 8 9 10

How well are things going overall?

1 2 3 4 5 6 7 8 9 10

Please read this list and check the items of concern to you:

_____ 1. Adjustment to college
_____ 2. Academic concerns
_____ 3. Feeling unmotivated
_____ 4. Unsure of career choice
_____ 5. Financial problems
_____ 6. Procrastinating
_____ 7. Feeling helpless
_____ 8. Headaches
_____ 9. Disorganized
_____ 10. Eating less/more
_____ 11. Spiritual problems
_____ 12. Isolating self
_____ 13. Feel that others do not like me
_____ 14. Skipping class
_____ 15. Feeling hopeless
_____ 16. No close friends
_____ 17. Romantic problems
_____ 18. Feeling anxious
_____ 19. Tightness in chest
_____ 20. Compulsive
_____ 21. Nervous/Worrying too much
_____ 22. Anger
_____ 23. Thoughts of harming another
_____ 24. Feeling guilty
_____ 25. Grief/Loss
_____ 26. Abortion
_____ 27. Loss of interest in things
_____ 28. Lonely
_____ 29. Difficulty expressing my emotions
_____ 30. Feeling depressed/Sadness
_____ 31. Discouraged about my future
_____ 32. Feeling inferior
_____ 33. Afraid of making mistakes
_____ 34. Failure or rejection
_____ 35. Recklessness
_____ 36. Feeling unlovable
_____ 37. Sexual matters
_____ 38. Acting aggressively
_____ 39. Sexual assault/Rape
_____ 40. Impulsive
_____ 41. Thoughts of suicide: within last 24 hours ___ within last week ___ within last 6 months ___ other ___
_____ 42. Attempting suicide : within last 24 hours ___ within last week ___ within last 6 months ___ other ___
_____ 43. Have you had any serious illness or injuries in your life? If yes, please list:

_____

_____ 44. Have you tried to control your weight?
If yes, How? Dieting ____ Exercise ____ Vomiting ____ Laxatives ____
_____ 45. Has there been a death of anyone close to you in the last five years? If yes, who?

_____

_____ 46. Worried about body image
_____ 47. Difficulty sleeping
_____ 48. Student conduct concerns
_____ 49. Uncertain about sexual identity
_____ 50. Own use of drugs/alcohol
_____ 51. Afraid of making mistakes
_____ 52. STD/HIV/AIDS
_____ 53. Parental conflict
_____ 54. Family problems/pressure
_____ 55. Abuse: emotional ___ sexual ___ physical ___
_____ 56. Irritability
_____ 57. Dizziness or light headedness
_____ 58. Sudden changes in personality or behavior
_____ 59. Feeling disconnected
_____ 60. Vomiting
_____ 61. Loss of memory
_____ 62. Health worries
_____ 63. Feeling unattractive
_____ 64. Experiencing mood shifts
_____ 65. Trust issues
_____ 66. Numbness/tingling
_____ 67. Sleep problems/nightmares
_____ 68. Out of control
_____ 69. Thoughts of worthlessness
_____ 70. Stressed
_____ 71. Feeling numb
_____ 72. Roommate problems
_____ 73. Afraid
_____ 74. Legal concerns
_____ 75. Uncertain about gender identity
_____ 76. Unable to concentrate
_____ 77. Has any member(s) of your family been diagnosed with a mental illness
_____ 78. Please mark all of the following thoughts that apply at this time:
_____ confused
_____ intrusive
_____ irrational
_____ obsessive
_____ bizarre
_____ 79. Do you have the desire or need to harm yourself through:
cutting____ burning ____ severing ___ inserting ___
hitting____ constricting____ picking___
other _____
80. How many people can you really count on right now, for emotional support? One or less ___ Two to four ___ Five or more ___