



INTAKE FORM

PERSONAL INFORMATION

Today's Date _____

First Name _____ Last Name _____ A# _____

Local Address _____ City/State/Zip Code _____

Hometown (City and State) _____

Email Address _____ Date of Birth _____ Age _____

Employed at _____ Hours Per Week _____

Race:	Relationship Status:	Gender:	Primary Attraction:	Veteran:
<input type="checkbox"/> African American/ Black	<input type="checkbox"/> Single	<input type="checkbox"/> Male	<input type="checkbox"/> Male	<input type="checkbox"/> Yes
<input type="checkbox"/> Hispanic American/ Latino	<input type="checkbox"/> Partnered	<input type="checkbox"/> Female	<input type="checkbox"/> Female	<input type="checkbox"/> No
<input type="checkbox"/> Asian/ Pacific Islander	<input type="checkbox"/> Married	<input type="checkbox"/> Other	<input type="checkbox"/> Both	
<input type="checkbox"/> Native American	<input type="checkbox"/> Divorced		<input type="checkbox"/> Neither	
<input type="checkbox"/> Caucasian American/ White	<input type="checkbox"/> Widowed			
<input type="checkbox"/> Multiracial	<input type="checkbox"/> Separated			
<input type="checkbox"/> Other: _____				

COUNSELING INFORMATION

Reason for Coming to the Counseling Center:	Please indicate who referred you to the Counseling Center:	
<input type="checkbox"/> Personal	<input type="checkbox"/> Self	<input type="checkbox"/> Campus Police
<input type="checkbox"/> Mandatory	<input type="checkbox"/> Friend	<input type="checkbox"/> Professor/ Instructor/ Faculty
<input type="checkbox"/> Academic	<input type="checkbox"/> Parent/ Family	<input type="checkbox"/> Academic Advisor/ Student Success Center
	<input type="checkbox"/> Residence Hall Staff	<input type="checkbox"/> Student Health Center
	<input type="checkbox"/> Judicial Affairs	<input type="checkbox"/> Personal Physician

EDUCATIONAL INFORMATION

Enrollment Status:	Class Standing:	College:	What is your major?
<input type="checkbox"/> Full Time	<input type="checkbox"/> Freshman	<input type="checkbox"/> Administrative Science	_____
<input type="checkbox"/> Part Time	<input type="checkbox"/> Sophomore	<input type="checkbox"/> Engineering	_____
<input type="checkbox"/> Not Enrolled	<input type="checkbox"/> Junior	<input type="checkbox"/> Nursing	_____
Number of Credits: _____	<input type="checkbox"/> Senior	<input type="checkbox"/> Liberal Arts	_____
	<input type="checkbox"/> Graduate	<input type="checkbox"/> Science	GPA: Last: _____
		<input type="checkbox"/> Undeclared	
International Student: <input type="checkbox"/> Yes <input type="checkbox"/> No		Transfer Student: <input type="checkbox"/> Yes <input type="checkbox"/> No	

MEDICAL INFORMATION

What medical conditions are you currently being treated for? _____

Please list all medications you are currently taking: _____

Do you have a physician or other health provider? Yes No. Who (Name/ Type)? _____

Health Insurance Plan:

Student Insurance

Other Insurance (provider): _____

Not covered by insurance

CONTACT INFORMATION

If the UAHuntsville Counseling Center needs to contact you, would you prefer:

___ A non-identifying voicemail message (“This is Kristen, please call me at 256.824.6203”)

___ A message identifying the Counseling Center as the caller (“This is Kristen with the UAHuntsville Counseling Center, please call me at 256.824.6203”)

Please indicate your preferred contact number by checking the space to the left:

___ Home Phone () _____

___ Work Phone () _____

___ Cell Phone () _____

___ Other Phone () _____

HISTORY QUESTIONNAIRE

FAMILY INFORMATION

Relationship	Name	Age	Occupation	Education	Mental Health Concern? Yes/No?	Living or Deceased	Type of Relationship? +Positive -Negative 0 Neutral

*If your parents are divorced, how old were you? _____

Does anyone in your family have a history of alcohol/ substance abuse? ___ No ___ Yes

SOCIAL SUPPORT INFORMATION

With whom do you usually talk your problems or plans? _____

Are the majority of your friends local? ___ Yes ___ No. If not, where are they? _____

To which, if any, school, church, or religious organizations do you belong? _____

In case of emergency, please provide contact information for someone you would like us to contact:

Name _____ Relationship _____ Phone _____

SUBSTANCE USE

Do you drink alcohol? ___ No ___ Yes, less than once a week ___ Yes, 1-2 times a week ___ Yes, 3 or more times a week

If yes, how many drinks do you drink per day? ___ 1-3 drinks ___ 4-6 drinks ___ 7-9 drinks ___ 10+ drinks

Do you use any other substances? ___ No ___ Yes. If yes, please list: _____

How often? _____

Have you ever felt that you should cut down on your drinking/ substance use? ___ No ___ Yes

Have you previously been a client at the Counseling Center? ___ Yes ___ No If so, when? _____

Have you ever been in counseling or therapy or been hospitalized for mental health reasons? ___ Yes ___ No
If yes, when and where? _____

Are you presently receiving or seeking counseling from some person or agency other than this Counseling Center?
___ Yes ___ No With whom? _____

What is/are your primary concern(s) or worries you would like to discuss with your counselor?

What would you like to get out of counseling? _____

Please mark your most significant experiences over the last month.

FEELINGS

___ Helpless	___ Inferior	___ Depressed	___ Numb	___ Mood Shifts
___ Shameful	___ Stressed	___ Hopeless	___ Angry	___ Trapped
___ Guilty	___ Anxious	___ Out of control	___ Sensitive	___ Other: _____

THOUGHTS

___ Confused	___ Unattractive	___ Obsessive	___ Unintelligent	___ Unlovable
___ Distracted	___ Worthless	___ Disorganized	___ Unmotivated	___ Worry
___ Paranoid	___ Racing	___ Fearful	___ Other: _____	

BEHAVIORS

___ Skipping classes	___ Binge drinking	___ Injuring self	___ Poor peer relationships	___ Withdrawing socially
___ Procrastinating	___ Career/major choice	___ Acting out sexually	___ Acting aggressively	___ Impulsivity
___ Passivity	___ Substance use	___ Poor concentration	___ Crying	___ Lack of ambition
___ Sexual problems	___ Relationship issues	___ Nightmares	___ Avoidance	___ Spiritual problems
___ Finances	___ Parent/child conflicts	___ Compulsivity	___ Other: _____	

PHYSICAL SYMPTOMS

___ Insomnia	___ Tired	___ Dizziness	___ Pain	___ Weight gain or loss
___ Tightness in chest	___ Headaches	___ Rapid heart beat	___ Vomiting	___ Numbness or tingling
___ Excessive sleep	___ Eating problems	___ Other: _____		

List the three most significant experiences that you would to work on in counseling:

1. _____ 2. _____ 3. _____

HIGH RISK CONCERNS INFORMATION

Have you ever had thoughts of suicide?	___ No	___ Yes, when: _____
Have you ever had thoughts of death?	___ No	___ Yes, when: _____
Have you ever attempted to commit suicide?	___ No	___ Yes, when: _____
Have you ever had thoughts of hurting someone?	___ No	___ Yes, when: _____
Have you ever attempted to hurt someone else?	___ No	___ Yes, when: _____
Were you abused at any time in your life: Physically	___ No	___ Yes, when: _____
Emotionally	___ No	___ Yes, when: _____
Sexually	___ No	___ Yes, when: _____

UAHUNTSVILLE COUNSELING CENTER
INFORMED CONSENT

Eligibility— Any student currently enrolled in 3 or more credits at UAH is eligible to receive counseling services.

Counseling Sessions— The Counseling Center uses a brief counseling model. Brief counseling focuses on identifying specific and attainable goals where both the counselor and the client are active in the process. Clients are eligible for up to twelve sessions per academic year. For those that may require more sessions, the Counseling Center can provide referral options that are available locally. We ask that you notify us in advance if you will be unable to attend your appointment so we may offer that time to another student. If you are more than 10 minutes late, your appointment will be rescheduled. A counseling session is typically 45—60 minutes in length. Failure to attend sessions could result in being removed from the counselor’s schedule.

Email— We do not schedule appointments through email. We recognize the importance of email, but because it is not a secure medium of communication and our staff does not maintain 24-hour access to their email, it will not be used to discuss ongoing treatment issues.

Social Networking— The Counseling Center has a professional Facebook page. Please feel free to “like” this page as it can keep you up-to-date on programming and events that may be of interest to you. Our staff is discouraged from befriending any of their clients, current or not, on any of their personal social networking profiles.

Confidentiality— Several federal and state laws, as well as a code of professional ethics, protect the confidentiality of information shared in counseling. Counselors who work in the UAH Counseling Center may consult with one another about your case if it will benefit your treatment process.

The Counseling Center will release information from counseling sessions to outside parties only at the request of the client. Records are confidential and will not leave the Counseling Center unless there is an emergency situation. The Counseling Center records will never be a part of the educational record. Parents and guardians are not contacted unless we have permission from the client or if there is an immediate risk to the client’s safety (ie: suicide risk/ attempt, emergency room evaluation, and/or threat to themselves or others including abuse to a child or elderly person). Your counselor is legally required to release client information to the courts if a judge court orders your record. If such a situation arises, we will make every attempt to inform you of the court’s request.

Our office gathers demographic information on the students we serve. This information will be used to help in improving our services. Any demographic data derived from your involvement with the Counseling Center will be used in the aggregate insuring the anonymity of each individual. This information may be used only as expressly authorized by the client’s informed and uncoerced consent.

I accept _____(initial) decline _____(initial) my information to be used for statistical purposes.

If you have any questions regarding these policies, please discuss them with your counselor. Your signature implies that you have read, understand, and agree to the above policies. Please feel free to request a copy of this form for your records.

Signature

Date

Disclaimer: In order to better protect your confidentiality, please remember to keep this paperwork in a private location until your appointment time .