East Central University
Student Counseling Center
Intake Form

Today's Date:

Assigned Therapist: *(office use only)*

First Name:	Middle Name/Initial:	Last Name:	Preferred Name:

Date of Birth: ____/____/____ **Age:** _____

ECU ID#: _____

Are you seeking services due to COVID-19/effects of Pandemic? ☐Yes ☐No

Gender: ☐ Male ☐ Female
☐ Transgender ☐Non-Binary
Pronouns: _____

Primary Phone: _____

Email: _____

Is it okay for our office to email, call and/or send text appointment reminders to you?
☐ Yes ☐ No

Local Address:_____
_____
May we contact you at this address? ☐Yes ☐No

Permanent Address: _____
_____

Do you have health insurance coverage? ☐Yes ☐No

Are you an *International Student*?
☐ Yes ☐ No
If yes, please list country of origin:
_____

Emergency Contact Information:
Name: _____
Relation: _____
Address: _____
_____
Phone: _____

Relationship Status:
☐ Single ☐ Separated
☐ Married When? _____
How Long? _____ ☐Serious Dating
☐ Divorced ☐ Civil Union/
When? _____ Domestic Partnership

Sexual Orientation:
☐Asexual ☐Pansexual
☐Bisexual ☐Queer
☐Gay ☐Lesbian
☐Straight/Heterosexual
☐Questioning

Race:
☐ African-American / Black / African
☐ Asian American/Asian
☐ European American/White/Caucasian
☐ Hispanic/Latino/Latina
☐ Multi-Racial
☐ Native American
☐ Other (please specify):_____

ECU Status:
☐Freshman ☐Sophomore
☐Junior ☐Senior
☐Grad Student ☐Other:
_____

Are you a First Generation Student?
☐No ☐Yes

Are you a transfer student?
☐No ☐Yes If yes, please list from where/when: _____
_____

Major: _____

GPA: _____

Are you a student athlete? ☐No ☐Yes If yes, which team? _____

Are you in any clubs? Which ones? _____
_____

Are you affiliated with any Greek Organization ?
☐ No ☐ Yes If yes, please list which one:
_____

Please list your current classes:_____
_____
_____
_____

Are you registered w/the office for disability services on this campus, as having a documented and diagnosed disability? ☐Yes ☐No (please specify):
_____

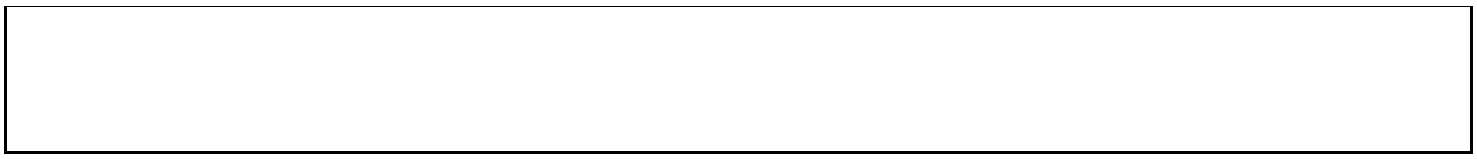
What kind of housing do you currently have?
☐ Off-campus apartment/house
☐ University Housing
☐ Other (please specify):
Dorm & Room #:
_____

Who referred you to our office?
☐Self ☐Friend ☐Parent or relative
☐Faculty/Staff (please specify name):
_____
☐Housing Staff ☐VP of Student Dev.
☐Health Services ☐ECU PD
☐Other: _____

With whom do you live? (check all that apply)
☐ Alone ☐Spouse, partner, or significant other ☐Roommate(s)
☐ Spouse, partner, or significant other ☐Parent(s) or guardian
☐ Children (specify ages) _____
☐ Other Family (please specify): _____
Is your family supportive? ☐Strongly Agree ☐Agree ☐Strongly Disagree ☐Disagree
Are your friends supportive? ☐Strongly Agree ☐Agree ☐Strongly Disagree ☐Disagree

Do we have permission to acknowledge the referral? ☐ no ☐ yes If yes, please sign below:
_____
(*This permission allows us to reveal that you followed up on the referral with this appointment.*)

Briefly describe what brings you to our office: _____
_____



What are your favorite recreational activities and/or school activities? _____

_____

_____

How many hours each week do you spend on hobbies/recreational activities/clubs?_____

What is the average number of hours you work per week? _____ Hours/wk

Job Title: _____

Employer: _____

How would you describe your financial situation right now?

☐ Always stressful ☐ Rarely stressful
☐ Often stressful ☐ Never stressful
☐ Sometimes stressful

Religious Preference: ***Optional***

☐ Christian ☐ Atheist
☐ Jewish ☐ No Preference
☐ Muslim ☐ Prefer not to answer
☐ Agnostic ☐ Other: _____

Describe if you wish: _____

_____

To what extent does your religious or spiritual preference play a role in your life? ***Optional***

☐ Very Important ☐ Sometimes important
☐ Important
☐ Neutral ☐ Unimportant
☐ Very unimportant

Have you ever been, or are you currently, enlisted in any branch of the US military (active duty, veteran, national guard/reserves)? ☐ Yes ☐ No

Did your military experiences include any traumatic or highly stressful experiences which continue to bother you? (e.g., war, combat, injuries, death, natural disasters, foreign deployment, etc.) ☐ Yes ☐ No

Think back over the last two 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?**

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

Think back over the last two weeks. How many times have you smoked marijuana?

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

Please check any other drugs you have used & indicate last date of use in blank:

☐ Cocaine/Crack _____
☐ Ecstasy _____
☐ LSD _____
☐ PCP _____
☐ Heroin _____
☐ Inhalants _____
☐ Non-Medical Use Prescription Drugs _____
☐ Other: _____ _____

Please indicate if/when you have had the following experiences: *Check one answer* ➡	No	Yes	**Please elaborate on each "yes" response.**
Have you attended counseling before today for mental health concerns?			When & why?
Have you taken a prescribed medication for mental health concerns?			When & what kind?
Have you been hospitalized for mental health concerns?			When? How many times? Why?
Have you received treatment for alcohol or drug use?			When? How many times?
Have you purposely injured yourself without suicidal intent (e.g. cutting, hitting, burning, hair pulling, etc.)?			How? How many times? When was the last injury?
Have you seriously considered attempting suicide?			How many times? When was the last time?
Have you made a suicide attempt?			How many times? When was the last time?
Have you seriously considered injuring another person?			When & who?
Have you intentionally injured another person?			When & who?
Have you had unwanted sexual contact(s) or experience(s)?			How many times? When & who?
Have you experienced harassing, controlling, and/or abusive behavior from another person (e.g. friend, family member, partner, or authority figure)?			How many times? When & who?

Have you experienced, witnessed, or learned of a traumatic event that involved actual or threatened death or serious injury, or a threat to the physical integrity of yourself or others? ☐ No ☐ Yes How many times? _____ If yes, please describe this event: _____ _____ _____	If you selected, "Yes" for the previous question, did the traumatic event(s) cause you to feel intense fear, helplessness, or horror? ☐ Yes ☐ No	Have you ever been convicted of a crime? ☐ Yes ☐ No

Any difficulties in childhood (e.g., re: walking, talking, reading, learning, behavioral, health, sleep, siblings, parents)? ☐ No ☐ Yes
If yes, please describe: _____

_____

Did you have any accommodations in school or were you on an IEP? ☐Yes ☐No (If yes, please explain): _____

_____

Please describe your family: _____

_____

_____

_____

Are you adopted? ☐ Yes ☐ No	Is there a family history of psychiatric concerns (e.g., substance abuse, depression, suicide, mania, anxiety, eating disorder, schizophrenia, psychiatric hospitalization)? ☐ No ☐ Yes If yes, please describe: _____
List any medications you are currently taking & please indicate type of physician prescribing the medications: _____ _____ _____ List any current physical health problems: _____ _____	_____ _____ _____ _____
List any academic problems or concerns that you may have: _____ _____	Do you currently have any sexual concerns? ☐ No ☐ Yes If yes, please describe: _____ _____

List Any Additional Concerns:	What are your expectations or desired outcomes of counseling services?

If you cannot attend your scheduled counseling session, please call 580-559-5714 and cancel 24 hours prior to the appointment.

Clients who frequently miss appointments will be given a referral to an outside counseling agency for services.

Client Signature: _____ **Date** _____

Treatment at the ECU Student Counseling Center is for all individuals regardless of race, ethnicity, gender, religion, sexual orientation, disability or class.