

East Central University Student Counseling Center Intake Form		Today's Date: _____		Assigned Therapist: <i>(office use only)</i>	
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 <i>International Student</i> ? ☐ Yes ☐ No If yes, please list country of origin: _____	
Emergency Contact Information: Name: _____ Relation: _____ Address: _____ Phone: _____		Relationship Status: ☐ Single ☐ Separated ☐ Married When? _____ How Long? _____ ☐ Divorced When? _____ ☐ Civil Union/ 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: _____ <i>(This permission allows us to reveal that you followed up on the referral with this appointment.)</i>			
Briefly describe what brings you to our office: _____					

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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 <u>right now</u> ? ☐ Always stressful ☐ Rarely stressful ☐ Often stressful ☐ Never stressful ☐ Sometimes stressful	
Religious Preference: <i>Optional</i> ☐ 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? <i>Optional</i> ☐ Very Important ☐ Sometimes important ☐ Important ☐ Unimportant ☐ Neutral ☐ 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 <u>last two weeks</u> . How many times have you had: <i>For males:</i> 5 or more drinks in a row? <i>For females:</i> 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 <u>last two weeks</u> . How many times have you smoked <u>marijuana</u> ? ☐ 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/ _____ ☐ Inhalants _____ Crack ☐ Non- _____ ☐ Ecstasy _____ ☐ Medical Use _____ ☐ LSD _____ ☐ Prescription _____ ☐ PCP _____ ☐ Drugs _____ ☐ Heroin _____ ☐ Other: _____ _____	
Please indicate if/when you have had the following experiences: <i>Check one answer</i> ➡		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** _____

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