

Date: _____ Do you attend: Illinois State University Other: _____

Name: _____ Male Female Prefer not to Identify

University ID Number: _____ - _____ - _____ **Please check preferred phone:**
please print legibly

Phone: (____) _____
 Cell Ph: (____) _____

Local Address: _____
Street Apt. #

City: _____ State: _____ Zip: _____

Permanent Address: _____

Name of an emergency contact person: _____ Phone: (____) _____
(This person would be contacted only if there was an urgent, immediate concern for your health/safety.)

May we use e-mail to contact you regarding appointment information? Yes No

Preferred e-mail address: _____

Please check all that apply:

- Native American/Alaskan Native
- Black/Non Hispanic
- White/Non Hispanic
- Asian or Pacific Islander
- Hispanic/Latino
- Other _____

Are you an **International Student**? Yes No If yes, from where? _____

University Classification: (please circle one)

- Freshman
- Sophomore
- Junior
- Senior
- Graduate
- Faculty/Staff
- Other _____

Birth date: ____/____/____ Age: _____

Campus Residence: (please circle one)

- Residence Hall
- Cardinal Court/Shelbourne
- Sorority, Fraternity or Co-op
- with Family in B-N
- Commuting from home
- Rented apartment/house in B-N
- Other (please specify) _____

Relationship Status: (please circle one)

- Single
- Dating
- Partnered
- Married
- Separated
- Divorced
- Widowed

GPA: _____ Are you on **academic probation**? Yes No

Major: _____ Hours enrolled this semester: _____

Are you a **transfer student**? Yes No If yes,

Name of school(s): _____ Dates: _____

Are you **employed**? Yes No If yes, hours per week: _____

Where: _____ Phone: _____

Any **religious or spiritual affiliations** you would like us to be aware of? _____

Are you a **member of a fraternity or sorority**? Yes No

List **health problems**: _____

List any **mental health medications and dosage** currently being taken: _____

List **other medications** currently being taken: _____

Have you had any **previous individual and/or group counseling or therapy**? Yes No *If yes, please specify where, when and why you stopped.*

How did you **learn about the SCS**? *(please circle one)*

- | | | | |
|---------------------|---------------------------------|----------------|----------------------|
| Self-referral | Friend | Faculty/Staff | Residence Hall Staff |
| Academic Advisement | Freshman Preview | Vidette | Brochure |
| ISU Catalog | PATH | Health Service | Parent |
| SCS Web site | Comm. Rights & Responsibilities | Campus Police | Romantic Partner |

Other: Please specify _____

On the following list, please place **two check marks** beside those items that **you wish to talk about today**. Then place a **single check mark** beside any other items that are **currently troubling** you.

- | | | |
|----------------------------------|--|------------------------------------|
| _____ Selecting/changing a major | _____ Social activities/involvement | _____ Problems with concentration |
| _____ Career choice or future | _____ Self-confidence/self-esteem | _____ Worrying |
| _____ Academic performance | _____ Lack of assertiveness | _____ Loss/grief/death |
| _____ Study skills | _____ Loneliness | _____ Suicide |
| _____ Test/Performance anxiety | _____ Legal matters | _____ Alcohol or drugs |
| _____ Making a decision | _____ Stress/anxiety/nervousness | _____ Unwanted habits |
| _____ Motivation/procrastination | _____ Depression | _____ Sexual matters |
| _____ Family relationship(s) | _____ Physical health | _____ Rape/sexual assault |
| _____ Peer relationship(s) | _____ Lack of energy/tiredness | _____ Pregnancy |
| _____ Romantic relationship(s) | _____ Problems with eating | _____ Anger Management |
| _____ Financial matters | _____ Problems with sleeping | _____ Other <i>(specify)</i> _____ |
| _____ Spirituality/Religion | _____ Cross-cultural/Cultural Identity | _____ |

Briefly state your main concern(s):

The degree to which you feel you can deal with your problem(s): *(please circle one)*

- (1) Not at all (2) Somewhat (3) Okay (4) completely

Given how you are getting along emotionally/psychologically, to what degree is your academic performance being affected? *(please circle one)*

- (1) I am not a student (2) No negative effect (3) Some negative effect
(4) Considerable negative affect (5) Extremely negative

What are your expectations for dealing with your concerns through counseling? *(please circle one)*

- (1) I doubt it can help (2) I hope it might offer some help
(3) I believe it will assist me in working through my concerns (4) I am sure that counseling will help me

If you have had prior contact with the SCS, how satisfied were you? *(please circle one)*

- (1) Not satisfied; it didn't help (2) Somewhat satisfied, but there were problems
(3) Quite satisfied; I just want some additional help (4) Very satisfied; it helped a lot

Comments: _____

Name: _____

Schedule: Please mark with an "X" times you **CANNOT** participate in counseling. The more times you leave open, the easier it will be to get assigned to a counselor or group.

_____ Fall _____ Spring _____ Summer

	Monday	Tuesday	Wednesday	Thursday	Friday	Notes:
8:00 am						
9:00 am						
10:00 am						
11:00 am						
12:00 pm						
1:00 pm						
2:00 pm						
3:00 pm						
4:00 pm						
5:00 pm						
6:00 pm						
7:00 pm						
8:00 pm						

Family Background

	Name	Age	Occupation
Parents/Guardians			
Brothers and Sisters			
Spouse/Partner			
Children			

PLEASE RETURN THE COMPLETED FORM TO THE FRONT DESK. THANK YOU.