

COUNSELING INITIAL INTAKE FORM

Student _____ Student ID # _____
(Last Name) (First Name)

Today's Date _____ Semester/Year _____
Sex: (Circle one) Male Female Date of Birth _____ Age _____

Residence Hall _____ Room # _____ Mail Box # _____
Phone: _____ O.K. to leave message on answering machine _____
e-mail: _____ with roommate (check one or both) _____
Local Address (if off campus) _____
_____ Zip Code _____

Current Marital Status _____ Spouse's Name (If applicable) _____
Number of Dependents _____ Ages _____

Academic CLASS (Please Circle) Freshman Sophomore Junior Senior Graduate
Major _____

Referral Source: Self ___ Other: (specify) _____

Emergency Contact: Name _____ Phone _____

Your Permanent Address _____
_____ Zip Code _____

Reason for seeking counseling (state what you think the problem is):

Have you ever had previous counseling? Yes _____ No _____

If yes, with whom? _____

(OVER)

Office Use Only:	
Counselor assigned: _____	Type: New _____
Date of response: _____	Continuing _____
Date of 1st session: _____	Code: _____
Method of payment: _____	

10/13/00

Name

TIME	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
8:30					
9:00					
9:30					
10:00					
10:30					
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8:00					