University of Connecticut- Greater Hartford Campus

Counseling & Wellness Center (CWC)

Student Information Form

(please print)

Today's Date: ____/____/____

Name: ____

Birthdate: _____/_____/_____ Age: ________ PeopleSoft ID#____

1. **LOCAL ADDRESS ____**

City: ____ State: _________ Zip Code: ______________________

Phone #: Home ( ) ___________________________________ Cell ( )____________________________________

E-mail Address: ____

***May we contact you by: Local Phone: Yes___ No___ E-mail: Yes___ No___**
Local Mail: Yes___ No___

2. **PERMANENT ADDRESS ____**

City: ____ State: _________ Zip Code: _________________________

Phone #: Home ( ) _________________________________ Cell ( )____

E-mail Address: ____

EMERGENCY CONTACT____ ____
(name) ***(relationship)***

( )____ ( )____
(work phone) ***(home phone)***

REFERRAL: Who referred you for counseling services?

Self____ Parent____ Faculty____ Staff ____ Agency ____ Court ____ Friend____ Other________________________________

Referral Name____ Department______________________________________
Academic Status: Undergraduate _____ Graduate _____ Non-degree______

Full-time___ Part-time___ Current Academic Probation? Yes___ No ___

Why have you come for counseling services?

____

____

____

____

____

____

CAREER INFORMATION

What is your employment status: employed ____ unemployed ____ retired ____ other ______________________________

If you are employed, how many hours do you work per week? _______

Job Title ____

Do you enjoy your job? Yes ___ No ___

Name ____

ACADEMIC ISSUES

Class Status ❑ **freshman** ❑ **sophomore** ❑ **junior** ❑ **senior** ❑ **graduate**

Program Major____ **GPA:**_______________

Program Minor ____

Career Objective ____

____

Are you having any difficulties with your academic studies? Yes ___ No ___ If yes, explain ________

____

Are you on academic probation? Yes ___ No ___

MEDICAL/PSYCHOLOGICAL INFORMATION

Primary Physician's Name ____

Phone # (   ) ___________________________________

Please specify any serious illnesses you have or have had:

____

____

Are you presently under medical/psychological care? Yes ___ No ___

If yes, please specify the reason/treatment____

____

Have you ever had any counseling or therapy (individual or group)? Yes ___ No ___
If yes, where and dates:____

____

Have you ever been hospitalized for psychiatric reasons? Yes ___ No ___
If yes, where? ____
When? ____
Reason: ____

____

Are you presently taking any medications? Yes ___ No ___

If yes, please specify the medication and dosage (include oral contraceptives and allergy medications, herbs, over-the-counter medications, and energy drinks).

____

____

Have you ever been hospitalized for medical/substance abuse reasons? Yes ___ No ___
Explain____

____

List any allergies you have, including allergic reactions to medications:_______________, __________

_______________, _______________, _______________, _______________, ____________, _______________

Name ____

LIFESTYLE ISSUES

Do you eat a healthy diet? Yes ___ No ___ Do you take vitamin/supplements Yes ___ No ___

If yes, please list ____
____

How do you cope with stress? ____
____

Do you exercise on a regular basis? Yes ___ No ___
If yes, what types of activities do you participate in? ____
____

List Extracurricular Interests/Activities____
____
____

Do you smoke cigarettes? Yes ___ No ___If so, how many? _______cigarettes/day
Do you want to quit smoking cigarettes? Yes ___ No ___
Have you tried to quit cigarette smoking in the past? Yes ___ No ___ How many times? ___________
What methods have you tried? ____

Do you indulge in non-prescription drugs? Yes ___ No ___
If yes, please list substances ____

Do you drink alcohol? Yes ___ No ___ If yes, how often do you drink? ______ day/week
Does drinking alcohol present any problems in your life? Yes ___ No ___
If yes, do you think you have a drinking problem? Yes ___ No ___ Do other people think you have a drinking problem? Yes ___ No ___

If you have a substance abuse problem, have you joined a '12 Step Program' or other support groups? Yes ___ No ___ Please list ____

Sexual Orientation: Heterosexual _____ Gay _____ Lesbian _____ Bi-sexual _____ Questioning _____
Prefer not to respond _____ Comment ____

Are you currently sexually active? Yes ___ No ___ Are you currently in a monogamous relationship with a partner? Yes ___ No ___ Have you ended a relationship recently? Yes ___ No ___

Have you ever been sexually abused? Yes ___ No ___ If yes, what age were you? _________
Are you being sexually abused currently? Yes ___ No ___ Have you reported the sexual abuse to someone? Yes ___ No ___
Who? friend____, family member____ law enforcement ____other ________

Do you have an eating disorder? Yes ___ No ___ If yes, what type? Anorexia ____ Bulimia ____
Other ____

Do you have a body image concern? Yes ___ No ___ If yes, are you abusing your body? Yes ___ No ___
If yes, describe ____

Do you have suicidal thoughts? Yes ___ No ___ Have you ever tried to commit suicide?
Yes ___ No ___ If yes, when? ____

Do you have trouble sleeping at night? Yes ___ No ___ If yes, what methods have you tried to aid you in falling to sleep?
____
____

Has a relative/significant other/friend died recently? Yes ___ No ___ If yes, who? ___________________

How have you been coping with your loss? ____

ADDITIONAL RELEVANT INFORMATION

____
____
____

Name ____

FAMILY INFORMATION

RELATIONSHIP STATUS: *(check one)*

Single______ Divorced________ Widowed______ Separated______ Civil Union______
Domestic Partner ______ How many years have you been single/partnered?______ (mos./yrs.)

Partner's Age:_____ Occupation: ____

Children/Step-children's ages:
______, ______, ______, ______, ______, ______, ______, ______, ______, ______, ______, ______, _______

Religious/Faith Preference:
Yours_______________________ Parent__________________________ Parent _______________________________

Country of Origin:
Yours_______________________ Parent __________________________ Parent_______________________________

Parents' Relationship Status ___________________________________

If re-partnered, year: Parent ____________ Parent ____________

	AGE	EDUCATION	OCCUPATION
(If deceased, give date)			
Parent	_________________	_________________________	_______________________
Parent	_________________	_________________________	_______________________
Step-parent	_________________	_________________________	_______________________
Step-parent	_________________	_________________________	_______________________
Siblings	_________________	_________________________	_______________________
	_________________	_________________________	_______________________

Has anyone in your family ever been treated for psychological problems? Yes ___ No ___

If yes, who? ____

When? ____

Type(s) of problems? ____

Does any member of your family abuse (or in the past abused) alcohol, drugs or other substances? Yes ___ No ___ If yes, who?____

List the substances used____
____
____
____

MILITARY SERVICE

Are you currently serving in the military? Yes ___ No ___ Are you a Veteran? Yes ___ No___
If yes, what branch of the military did you serve OR are currently serving? _______________________________________
How long did you serve to date? _____________________ (mos./yrs.)
Were you injured while serving military duty? Yes ___ No___ If yes, describe your injuries?
____
____

Does/Did your military experience have/had a negative impact on your ability to function OR on your family relationship?
Yes ___ No___ If yes, please explain ____
____
____
____

DEMOGRAPHIC INFORMATION (optional)

[information used only for statistical data]

Gender: Male _____ Female _____ Transgender _____ Other ____

RACE/ETHNICITY

African/Black, Non-Hispanic _____ **Asian/Pacific Islander _____**

Caucasian/White, Non-Hispanic _____ **Hispanic, Latino(a), Chicano(a) _____**

Native American/American Indian _____ **Bi-racial/Bi-ethnic _____**

Multi-racial/Multi-ethnic _____ **Other ____**

Are you an international student? Yes ___ No ___If yes, from what country? _________________________

MILITARY STATUS: Active _____ Reserves _____ Retired ______ Other ____________________________________

Served in ____ **Years of Active Duty: _______yrs.**

military branch