

CARROLL COLLEGE WELLNESS CENTER CLIENT INFORMATION FORM		Today's Date: _____		Assigned Counselor (office use only)	
First Name: _____		Middle Name/Initial: _____	Last Name: _____		Preferred Name: _____
Date of Birth: _____/_____/_____		Current Age: _____		Carroll ID#: _____	
Mailing Address: _____ _____ _____		Emergency Contact Information: Name: _____ Relation: _____ Address: _____ _____ Phone: _____		Relationship Status: <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Serious How long? _____ dating or <input type="checkbox"/> Divorced committed When? _____ relationship <input type="checkbox"/> Separated When? _____	
Student ph: _____		Ethnic Origin: <input type="checkbox"/> African American/Black <input type="checkbox"/> Asian American <input type="checkbox"/> European American/White/Caucasian <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Native American/First Nations <input type="checkbox"/> Other (please specify): _____		Carroll Status: <input type="checkbox"/> Freshman <input type="checkbox"/> Sophomore <input type="checkbox"/> Junior <input type="checkbox"/> Senior <input type="checkbox"/> Faculty/Staff <input type="checkbox"/> Other: _____	
Major: _____		GPA: _____		Are you a transfer student: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list where/when: _____ _____	
What kind of housing do you currently have? <input type="checkbox"/> Residential <input type="checkbox"/> Off campus apt. or house <input type="checkbox"/> Other (please specify)					
Who referred you to our office? <input type="checkbox"/> Self <input type="checkbox"/> Friend <input type="checkbox"/> Parent or spouse <input type="checkbox"/> Faculty/Staff (please specify name): _____ _____ <input type="checkbox"/> Health Services <input type="checkbox"/> Community Living Staff <input type="checkbox"/> Coach/Athletic Trainer <input type="checkbox"/> Other _____			What are your concerns that bring you to Counseling Services today (top three concerns)? 1. _____ _____ 2. _____ _____ 3. _____ _____		
Do we have permission to acknowledge the referral? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please sign below: _____ (This permission allows us to reveal that you followed up on the referral with a counselor, no other information is provided.)			What are the positive aspects of your life? _____ _____ _____ _____		

Please indicate if/when you have had the following experiences?	No	Yes	Please elaborate any "yes" response.
Have you attended counseling before today for a mental or emotional relationship/psychological or health concerns?			When & why?
Are you currently taking any medications?			List: Prescribing Physician:
Have you had any suicide thoughts or made a suicide attempt?			When?
<p>Are you currently experiencing, or have experienced in the past any physical or emotional difficulties?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If Yes, please describe: _____</p> <p>_____</p> <p>_____</p>			
<p>Is there, or has there been, any mental or emotional issues in your family (e.g. alcoholism, other addictions, depression, anxiety, bipolar, etc.)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If Yes, please describe: _____</p> <p>_____</p> <p>_____</p>			
<p>What are your favorite recreational, school activities, organizations, or volunteer work?</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>What is the average number of hours you work per week (if employed)? _____ Hours/wk</p> <p>Job title: _____</p> <p>Employer: _____</p>	<p>How would you describe your financial situation right now?</p> <p><input type="checkbox"/> Always stressful</p> <p><input type="checkbox"/> Often stressful</p> <p><input type="checkbox"/> Rarely stressful</p> <p><input type="checkbox"/> Never stressful</p> <p><input type="checkbox"/> Sometimes stressful</p>	<p>Describe your sleep patterns:</p> <p>_____ average # of hours sleep per night</p> <p>Difficulty getting to sleep:</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Difficulty staying asleep:</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Early Waking & can't get back to sleep:</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Do you have any physical health problems? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If Yes, please describe:</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Do you have a diagnosed & documented disability? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If Yes, please specify type:</p> <p>_____</p> <p>Are you currently receiving any accommodations from the Academic Resource Center? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>If you are a student, how would you characterize your college academic experiences:</p> <p><input type="checkbox"/> Overall easy transition</p> <p><input type="checkbox"/> Initially a struggle, now transitioned</p> <p><input type="checkbox"/> Continue to struggle with limited academic problems</p> <p><input type="checkbox"/> On-going struggle with most or all areas of academic functioning</p>	

Signature of Client: _____

Date: _____

Signature of Counselor: _____

Date: _____