

PERSONAL INFORMATION UPDATE

Counseling Services

CONFIDENTIAL



Term: Fall ___ Spring ___ Summer ___

Today's Date: _____

Please answer the following questions as completely as possible. This information will be useful to your counselor. Thank you.

Name _____ Preferred Name: _____
Last First Middle

Age _____ Birthdate _____ Gender _____ Student ID # _____

Local Address _____
Street address City State Zip

Permanent Address _____
Street address City State Zip

Local Phone number _____ Cell Phone Number _____ Work Phone Number _____

May we call you at home? Yes No ; at Work? Yes No ; Cell Phone? Yes No
May we contact you via e-mail? Yes No ; E-mail address: _____

1) Referring person/agency for this visit: Parents Advisor Faculty/Staff Residence Life
Health Services Other Who referred you? _____

2) Are you currently taking any medications? If so please list. _____

3) What has changed for you since you last sought counseling services at Carroll College? _____

4) Please rank your most pressing concerns: 1.) _____

2.) _____

3.) _____

5) What do you hope to accomplish during counseling? _____

6) Confidentiality statement reviewed with student:

Counselor Signature

Date