



Student Health and Wellness Center

Confidential Counseling Intake Form

Potential billing costs: SHW Behavioral Health appointments are not billed to insurance and are of no cost to students, however, labs and prescribed medications are subject to insurance coverage costs. Please ask our front desk team, your provider, or refer to our Costs of Services sheet if you have any questions or concerns about billing.

Welcome to Student Health & Wellness Center.

Name: _____ Age: _____ Pronoun(s) used: _____

How would you prefer to be addressed? _____

Program/School/ Postdoctoral field: _____

Estimated Graduation/Completion date: _____

What would you like us to know about your identities? (sexual orientation, abilities, gender, gender identity, culture(s), race, religion etc.) _____

Please briefly describe the reason(s) for your visit today:

GAD-7: Over the last 2 weeks, how often have you been bothered by the following problems (circle)

	Not at all	Several	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

Column totals _____ + _____ + _____ + _____

Total score _____

If you checked off any of the above problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all
 Somewhat difficult
 Very difficult
 Extremely difficult

Please continue on the next page

PHQ-9: Over the *last 2 weeks*, how often have you been bothered by the following problems (circle)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep, sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself- or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite-being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

Column totals _____ + _____ + _____ + _____

Total score _____

If you checked off any of the above problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all
 Somewhat difficult
 Very difficult
 Extremely difficult

Previous treatment:

Have you had counseling in the past? Yes No

If yes, please describe where: _____ *when:* _____

Have you had a prior psychiatric hospitalization?: Yes No *If yes, Where:* _____

When: _____ *Please briefly describe:* _____

Please continue on the next page

Please list *Current* behavioral health medications with dosage:

Please list *Previous* behavioral health medications:

In the past year

I have been concerned about my safety in my romantic relationship(s):

Never Rarely Sometimes Frequently Always N/A

I feel comfortable sexually in my romantic relationships:

Never Rarely Sometimes Frequently Always N/A

I have been personally impacted by discrimination, oppression, and/or microaggressions by others:

Never Rarely Sometimes Frequently Always N/A

Do you have a current or past history of an eating disorder? Yes No

Substance Use (Indicate number per day):

Nicotine: Cigarettes: _____ per day e-cigarette: _____ per day Other: _____ None

Caffeine: specify type(s) and quantity per day: _____ None

Alcohol: _____ drinks per day _____ day(s) of the week of (specify type) _____ None

Cannabis: smoke vape edible _____ per day _____ days of the week None

Other (opiate/hallucinogens/cocaine etc): _____ None

Previous substance use treatment: _____ None

Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?

Yes No

In the last year have you drunk alcohol or used drugs more than you meant to? Yes No

Are the guns in your home secured?

Yes No I don't have guns

Is there anything else you would like us to know?
