Student Health and Wellness Center
Confidential Behavioral Health Intake Form

Potential billing costs: SHW Behavioral Health appointments are not billed to your insurance and are of no cost to you. 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.

Name: _____
How would you prefer to be addressed?: _____
Age: _____ Pronoun(s) used: _____
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:

_____
_____
_____
_____
_____

Please list **current** behavioral health medications with dosage and response/side effects:

_____
_____
_____
_____

Please list **previous** behavioral health medications with dosage and response/side effects:

_____

_____

_____

_____

Please list any additional prescribed, over the counter, or herbal/alternative medications with dosage:

_____

_____

_____

_____

Substance Use:

Please answer if you use the following substances, indicating the type and quantity:

Nicotine: ☐Yes (please describe below) ☐ No
Type: _____ Quantity per day: _____ Days per week:_____

Caffeine: ☐Yes (please describe below) ☐ No
Type: _____ Quantity per day: _____ Days per week:_____

Alcohol: ☐Yes (please describe below) ☐ No
Type: _____ Quantity per day: _____ Days per week:_____

Cannabis: ☐Yes (please describe below) ☐ No
Type: _____ Quantity per day: _____ Days per week:_____

Other (opiates, hallucinogens, cocaine, etc): ☐Yes (please describe below) ☐No
Type: _____ Quantity per day: _____ Days per week:_____

Have you ever felt you wanted or needed to cut down on your drinking or drug use?
◯ Yes (please describe below) ◯No

_____

_____

_____

Previous substance use treatment?
◯Yes (please describe below) ☐No

_____

_____

_____

Media and Technology Use

Do you use any media/technology platform (social media, AI, gaming, etc.) on a regular basis?

☐Yes (Which ones? _____) ☐No

Please describe any benefits and/or drawbacks to your use of these platforms and whether you utilize AI as part of your regular support system.

_____
_____
_____
_____
_____
_____
_____
_____

History

Are the guns in your home secured? ☐ I don't own guns. ☐Yes ☐No

Do you feel safe in your current romantic relationship (s)? ☐Yes ☐No ☐N/A

Have you had a prior psychiatric hospitalization? ☐Yes ☐No

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

STOP – Proceed to the next section only if you are scheduled to see a psychiatrist.

Health History

Please check if you have a **history** of the following:

☐Seizures. If checked, please describe: _____

☐Head Trauma. If checked, please describe: _____

☐Thyroid disease

☐Vitamin D deficiency

☐Anemia

☐Headaches

☐Asthma

☐Hypertension

☐Heart Arrhythmias

☐Sleep apnea

☐Bleeding disorder

☐Glaucoma

☐Liver disease

☐Kidney disease

Contraception Use

Please check what method(s) you are **currently** using:

☐Condom

☐IUD

☐Pill

☐Patch

☐Nexplanon

☐Ring

☐Tubal Ligation/Vasectomy

☐Rhythm

☐Plan B

☐Depo-Provera injections

☐N/A

☐None

☐Other (please describe) _____

Physical Symptoms

Please check any physical symptom (s) that you are **currently** experiencing:

☐Weight gain
☐Weight loss
☐Change in appetite
☐Chest pain
☐Abnormal heart rhythm
☐Blurred vision
☐Snoring
☐Pain
☐Tremor
☐Headache
☐Dizziness
☐Fatigue
☐Nausea
☐Constipation
☐Diarrhea
☐Pregnant/trying to conceive
☐Breastfeeding
☐Other (please describe):

_____
_____
_____
_____
_____