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

Patient Health Questionnaire (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all (0)	**Several days (1)**	**More than half the days (2)**	**Nearly every day (3)**
Little interest or pleasure in doing things	☐	☐	☐	☐
Feeling down, depressed, or hopeless	☐	☐	☐	☐
Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
Feeling tired or having little energy	☐	☐	☐	☐
Poor appetite or overeating	☐	☐	☐	☐
Feeling bad about yourself—or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
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	☐	☐	☐	☐
Thoughts that you would be better off dead, or of hurting yourself	☐	☐	☐	☐
	Add columns:	_____ +	_____ +	_____
			TOTAL:	_____

	Not difficult at all	**Somewhat difficult**	**Very Difficult**	**Extremely Difficult**
If you checked off *any 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?	☐	☐	☐	☐

GAD-7

Over the last ***2 weeks***, how often have you been bothered by the following problems?

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

Add columns: _____ _____ _____

TOTAL: _____

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):

_____
_____
_____
_____
_____