New Client Information

About You: Thank you for coming to counseling at the Cooper Center. To make your time in counseling more productive, please assist the professional staff by completing the questionnaire. The questions are designed to provide information for the purpose of knowing you better. The information that you provide will be held in strict confidence. Naturally, we encourage you to take your time and learn from your responses. Please omit any questions that do not apply to you. Thank you.

Please fill in with blue or black pen.

Contact Information

Name: _____ Date: _____

Dorm: _____ Campus Mailbox: _____ Home Address: _____

RA: _____ RD: _____

Home: _____ Cell: _____ Email: _____

I give permission for you to leave voicemails at: ☐ Home and/or ☐ Cell Permission to send emails to the above email address? ☐ N ☐ Y

_____ *Please initial to indicate you understand Trinity e-mail communication is not encrypted, therefore it is not a completely confidential means of communicating and it is recommended it is used for scheduling purposes. Every effort will be made to keep emailed information private; however, very personal information is best shared in person.*

Date of Birth: _____ Age: _____ ☐ Male ☐ Female ☐ Transgendered ☐ Intersex

Who referred you? ☐ Self ☐ Parent ☐ Roommate ☐ Faculty/RA/RA ☐ Therapist/Dr., _____ ☐ Other, _____

Primary Emergency Contact Information:

Note: The emergency contact information is only used in case of a medical emergency in this office. Providing this information does not permit us to share any information regarding your care and it is not a Consent to Release.

Name: _____ ☐ Mother ☐ Father ☐ Spouse ☐ Other, relationship:_____

Home: _____ Work: _____ Cell: _____

☐ I do not wish to provide an emergency contact. I understand the Cooper Center will follow school protocol for emergencies.

Ethnicity: ☐ Asian ☐ Biracial ☐ Black/African American ☐ Caucasian ☐ Latino/a ☐ American Indian ☐ Other: _____

Religion/Spirituality

☐ Protestant ☐ Catholic ☐ Jewish ☐ Buddhist ☐ Muslim ☐ Spiritual, not religious ☐ Non-religious ☐ Other: _____

Church Affiliation: _____ Denomination: _____

Importance to you: ☐ None ☐ Minimal ☐ Moderate ☐ Significant Do you want your faith to be included in your counseling sessions? ☐ Yes ☐ No

Academic, Military and Work History

Did you transfer from another school? ☐ N ☐ Y, transferred from: _____ Year: _____

Year in college: ☐ FR ☐ SO ☐ JR ☐ SR ☐ Adult Studies ☐ Graduate School ☐ Other: _____

Enrollment: ☐ FT ☐ PT ☐ On Campus ☐ Commuter ☐ Other: _____

Major/s: _____ Minor/s: _____

Any specific problems while you were in school? _____

Have you been evaluated for learning disabilities? ☐ N ☐ Y, _____ Have you been to the Office of Learning Services? ☐ N ☐ Y, _____

Current Vocational Status

Place of Employment: _____ Employment Status: ☐ Campus ☐ Off-Campus ☐ PT ☐ FT Hrs/week: _____

How long have you had your present job? _____ Are you having problems at work? _____

Are/Have you served in the military? ☐ N ☐ Y, what branch? _____ Were you deployed? ☐ N ☐ Y, what did you do? _____

Family History

Please list your immediate family members and their ages.

Name	Age	Relationship	Name	Age	Relationship

Parents' current marital status: ☐ Married ☐ Separated ☐ Divorced ☐ Other: _____

In two or three words, describe your family: _____

Briefly describe the nature of your relationship with your immediate family, and note any questions or concerns you might wish to discuss in session.

_____

_____

Friends and Relationship History

Do you have good friends or a support system that you can consistently rely upon? ☐ No ☐ Yes

Please describe the role that your friends or support system play in your life: _____

_____

Relationship status: ☐ Single ☐ Engaged ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Other: _____

How long have you been in this relationship? _____

Please share any concerns or questions about your relationship that you would like to discuss: _____

In two or three words, describe your partner: _____

Medical and Mental Health History

Primary Care Physician Name: _____ Phone: _____

Address: _____

Last seen: _____ Reason for Treatment: _____

Psychiatrist Name: _____ Phone: _____

Address: _____

Last seen: _____ Reason for Treatment: _____

Please list all previous hospitalizations you have received.

Date	Hospital	Length of stay	Cause for admission	In / Outpatient
				☐ In ☐ Out
				☐ In ☐ Out

Have you had thoughts of or attempted suicide in the past? ☐ N ☐ Yes, when? _____

Have you ever been hospitalized for suicidal thoughts/actions? ☐ No ☐ Yes, where? _____ Year: _____

Medical Concerns

Please list any current or chronic medical issues (i.e., allergies, high blood pressure, mono, seizures, diabetes, cardio problems, cancer, TB etc.): _____

_____

Please list any illnesses or disabilities that have affected you or a family member in the past year: _____

_____

Please list all medications currently prescribed:

Medication	Reason	Dosage	Frequency	Monitoring Physician	Start Date	End Date

Counseling Services

Previous experience with counseling: ☐ None ☐ Individual ☐ Marriage & Family ☐ Group ☐ Addictions ☐ Other: _____

Previous experience at Cooper Center: ☐ None ☐ Personal/Group ☐ Career Guidance Who did you see? _____

Was counseling helpful? ☐ No ☐ Yes

History of alcohol use? ☐ No ☐ Yes, explain _____

History of drug use? ☐ No ☐ Yes, explain _____

Have others been concerned about your use? ☐ No ☐ Yes, explain _____

Current Difficulties and Goals for Counseling

Please check how the following symptoms are currently causing you the most difficulty.

	Never	Sometimes	Often
Addiction			
Alcohol and drug			
Angry outbursts, temper			
Anxiety, stress, panic attacks			
Depression			
Eating			
Family			
Sleep problems and fatigue			
Fears or fearfulness			
Financial			
Grief and loss			
Health			
Organization and time mngt.			
Relationships: friends, family, significant. other			
Spiritual			
Work and school			

When would you say the problems began? _____ Have you sought treatment for these problems in the past? ☐ No ☐ Yes, date: _____

Please state in your own words the reason/s you are requesting help.

_____ _____

_____ _____

What goals do you have for counseling?

_____ _____

_____ _____

How would you describe how hopeful you are about counseling?

hopeless somewhat hopeless not sure somewhat hopeful hopeful

Thank You!

Please see backside for Notice of Privacy Practices