

**Integrated Health and Well-being Center Intake Form**

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ T#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Last) (First) (MI)

Preferred Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: \_\_\_\_\_ Male \_\_\_\_\_Female \_\_\_\_\_Other

D.O.B: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Age: \_\_\_\_\_\_\_ Race: \_\_\_\_ American Indian or Alaska Native
 \_\_\_\_ Asian
 \_\_\_\_ Black or African American
 \_\_\_\_ Native Hawaiian or Other Pacific Islander
 \_\_\_\_ White or Caucasian

 \_\_\_\_ Hispanic or Latino

Relationship status: \_\_\_\_ Single \_\_\_\_ Partnered \_\_\_\_ Married \_\_\_\_ Separated \_\_\_\_ Divorced \_\_\_\_ Other

Classification (circle one): Freshman Sophomore Junior Senior Graduate

Major: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Credits enrolled: \_\_\_\_\_\_ GPA:\_\_\_\_\_\_

Do you live on-campus? Y N Residence Hall: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Roomate(s)? Y N

Current Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Street City State Zip code

Permanent Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Street City State Zip code

Phone number: ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ok to call? Y N Ok to leave a message? Y N

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Okay to email? Y N

Who referred you to this office? \_\_\_\_\_ Self \_\_\_\_Friend \_\_\_\_ Family \_\_\_\_ Faculty \_\_\_\_ Advisor \_\_\_\_ RA

 \_\_\_\_\_ Disability Services \_\_\_\_\_Other

Are you a veteran? Y N Are you a member of ROTC? Y N Have you ever been enlisted? Y N

Emergency contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Name) (Number) (Relationship)

Briefly describe your reason for seeking services today: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been treated or hospitalized for your physical or mental health concerns recently? Y N

Within the past year? Y N If so, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any medications, non-prescription drugs, or herbal supplements of any kind you are currently taking

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you pregnant? Y N If yes, delivery date? \_\_\_\_/\_\_\_\_/\_\_\_\_ If no, do you take birth control? Y N

Do you have any serious or chronic medical problems? Y N If yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you registered with the Office of Disability Services at TSU? Y N If yes, please indicate what category you registered for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any allergies? Y N If so, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke, chew tobacco, or recreational products? Y N If yes, how often? \_\_\_\_\_\_ per \_\_\_\_\_\_\_\_\_\_\_\_

Do you consume alcoholic beverages? Y N In the last 30 days, how many days did you drink? \_\_\_\_\_\_\_\_\_

Please check the following boxes that apply to your current or past medical history:

|  |  |  |  |
| --- | --- | --- | --- |
| Asthma/ Respiratory |  | Bone or Joint Injury |  |
| Chicken Pox |  | High Blood Pressure |  |
| Frequent Ear Infections |  | Liver Disease/ Hepatitis |  |
| Vision Problems |  | Diabetes Type 1 |  |
| Hear Problems |  | Diabetes Type 2 |  |
| Skin Problems/ Eczema |  | Kidney Disease/ Bladder Infection |  |
| Tb/ Lung Disease |  | Physical or Learning Disabilities  |  |
| Seizures/ Epilepsy |  | Bleeding Disorders/ Hemophilia |  |
| Sexually Transmitted Diseases |  | Emotional or Behavioral Problems |  |
| Physical/ Emotional/ Sexual Abuse |  | Trauma |  |
| Emotional or Behavioral Problems |  | Surgery |  |

Please list any conditions or diseases not listed above: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had previous counseling? Y N If yes, at TSU Counseling Center? Y N If so, when? \_\_\_\_\_\_\_\_\_

If yes at another site, where and when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**General Information:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Always stressful** | **Often Stressful** | **Sometimes Stressful** | **Rarely Stressful** | **Never** |
| How would out describe your financial status right now? |  |  |  |  |  |
| How would you describe your financial situation growing up? |  |  |  |  |  |
| Indicate how much you agree with this statement: **“I get the emotional help and support I need from my family.”** |  |  |  |  |  |
| Indicate how much you agree with this statement: **“I get the emotional help and support I need from my social network”** (friends, colleagues, community/ organizational support) |  |  |  |  |  |

Please estimate the number of hours per week you are actively in **organized extracurricular activities** (ex. Sports, clubs, SGA, etc.) \_\_\_\_\_\_\_\_\_

Do you compete on sports teams that compete with other universities? Y N

 Are you the **first generation** in your family to attend college? Y N

What is the average number of hours you work per week during the school year (paid employment only) \_\_\_\_\_

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Symptom | Never/Rarely | Several Days | Nearly everyday | Symptom | Never/Rarely | Several Days | Nearly everyday |
| Feelings of Guilt |  |  |  | Memory loss |  |  |  |
| Worrying |  |  |  | Thinking about death |  |  |  |
| Too much energy |  |  |  | Thinking of suicide |  |  |  |
| Aggression |  |  |  | Family problems |  |  |  |
| Emotional abuse of self or others |  |  |  | Brooding about the past |  |  |  |
| Afraid of work/school |  |  |  | Crying excessively |  |  |  |
| Sleep walking |  |  |  | Feeling down or sad |  |  |  |
| Problems falling/staying asleep |  |  |  | Nightmares |  |  |  |
| Depression |  |  |  | Feeling Anxious |  |  |  |
| Hopelessness about the future |  |  |  | Struggles with social interaction |  |  |  |
| Trouble making decisions |  |  |  | Afraid to leave home |  |  |  |
| Feeling alone |  |  |  | Feeling impatient |  |  |  |
| Difficulty concentrating |  |  |  | No self confidence |  |  |  |
| Mood changes (sudden) |  |  |  | Shortness of breath |  |  |  |
| Restlessness |  |  |  | Rapid heart beat |  |  |  |
| Easily distracted |  |  |  | Chest pains |  |  |  |
| Problems getting along with others |  |  |  | Physical abuse to self or others |  |  |  |
| Feeling worthless |  |  |  | Lying |  |  |  |
| Overly tired |  |  |  | Problems at home |  |  |  |
| Poor or no appetite |  |  |  | Blackouts |  |  |  |
| Over eating |  |  |  | Stomach problems |  |  |  |
| Weight loss/gain |  |  |  | Fatigue |  |  |  |
| Vomiting |  |  |  | Feelings of unreality |  |  |  |
| Sleeping too much |  |  |  | Hallucinations |  |  |  |
| Hearing voices |  |  |  | Compulsive behavior |  |  |  |

**Family History:**

\_\_\_\_ Similar Difficulties \_\_\_\_ Anxiety \_\_\_\_Delusions \_\_\_\_ ADHD//Disruptive Behavior Disorder

\_\_\_\_ Learning Disability \_\_\_\_ Depression \_\_\_\_ Addictions \_\_\_\_ Personality Disorder \_\_\_\_\_ Mania \_\_\_\_ Other

**Developmental History**: *(include birth place, description of childhood, significant events, academic history, parent discipline, parents’ marital history, sibling relationships, etc.)*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Certification & Consent:**

**I, the undersigned, certify that all of the above medical information is true to the best of my knowledge and I have not omitted any pertinent information. I understand my information may be disclosed or shared with a provider (s) that have direct involvement in my treatment. I also understand that by signing this form, I have given my consent to have the information used for treatment purposes only.**

**Student Signature Date**

**Provider Signature Date**