WELLNESS CENTER
COUNSELING INTAKE FORM

Today's date: _______ Student ID #:_____Gender:_____

Name: _____ Date of birth: _____

Ethnicity:_____Education Level: _____Major:_____

Campus address: _____City: _____ State:_____ Zip:_____

Home address:_____City:_____State:_____Zip:_____

Phone (h): _____ (email): _____ (cell): _____

Emergency Contact Person: _____Phone: _____

Relationship to you: _____Referred by:_____

Do you work:_____Where:_____Position:_____

Counseling History

Have you had previous counseling:_____Dates:_____

Name of counselor:_____

Explain why: _____

Reason for this appointment request today:_____

List any concerns you have: _____

Are you currently taking any medications:What:_____Why:_____

Have you ever thought about, or attempted suicide:_____

Has anyone in your family, or friends committed, or attempted suicide:_____

If yes who:_____

What are your positives:_____

Please Complete if You Are Requesting Accommodations for Disability

Have you read The American Disability Act and student checklist requirements located in the University Catalog, Student Handbook, or on the Kettering website:_____

What type of disability do you have: _____

Do you have current documentation to prove your disability:_____

Who is providing the documentation:_____

(ie: Physician, Therapist, Psychiatrist, Psychologist, Special Education Program at school)

What type of service and/or accommodations do you feel you will need at this time:

_____

Personal History

Are you currently in a relationship:_____Length of time:_____

Family physician_____Name:_____City:_____State:_____

Date of last physician visit:_____Reason:_____

Current or past health issues you are concerned about_____What:_____

Hospitilizations:_____Dates:_____Why_____

Any death or losses significant to you:____Who:_____When:_____

Alcohol and Drug Use (Please Be Honest. This is Confidential)

Do you drink alcohol:_____How often:_____

	Used	Frequency
Marijuana	_____	_____
Crack	_____	_____
Cocaine	_____	_____
Tranquilizers	_____	_____
PCP	_____	_____
LSD	_____	_____
Heroin	_____	_____
Spice	_____	_____
Ecstasy	_____	_____

Family History

Name	Relationship	Sex	Age	Relationship Quality	Education/Occupation	Living/Deceased

Are your parents together:_____Date of divorce/separation:_____

Military and School

Have you served in the armed forces:_____When:_____What branch_____

Any other colleges before Kettering:_____When:_____Where:_____

Religious Information

Religious preference:_____How often do you attend worship:_____

Provide any other concerns that you may have:

_____

_____

Our Privacy Commitment to You: Your privacy is protected by law, but we are also very concerned that you feel safe in sharing your information in the counseling office. Only people who have the legal right and need may see your information. Unless you give us permission in writing we will only disclose your information for purposes of treatment, payment, business operations, or when we are required by law to do so.

Client Acknowledgement

By signing below I am verifying that I have read and understood the privacy policy of Kettering University Wellness Center and the counselor's professional disclosure statement.

Signature _____ Date_____