**AMERICAN UNIVERSITY OF ARMENIA**

**COUNSELING SERVICES**

**INTAKE FORM**

**Today's Date: _____**

**Student's Name: _____**
**(Student printed name)**

**CONTACT INFORMATION (check all that apply):**

**Permanent Address: _____**
**(street) (city) (state) (zip)**

**Cell Phone #: _____ ☐OK to phone ☐OK to leave message**

**Home or other Phone #: _____ ☐OK to phone ☐ OK to leave message**

**Preferred E-mail address: _____ ☐OK to email regarding your appointment**
**(Please be aware that email might not be confidential)**

**PREFERRED METHOD OF CONTACT:**

**☐Cell Phone: ☐ Home Phone: ☐Email: ☐Other (specify):_____**

**Person to notify in case of emergency: _____**

**Relationship to you:_____Telephone: _____**

**DEMOGRAPHIC DATA:**
**Date of Birth: _____ Sex:_____**

**Sexual Orientation: ☐Heterosexual ☐Lesbian ☐Gay ☐Bi-sexual ☐Questioning**

**☐Other ☐Prefer not to answer**

**Religious affiliation: _____**

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**Student Status: ☐Freshman ☐Sophomore ☐Junior ☐Senior ☐ Graduate**

**Major:_____ Minor (if you have one):_____**

**Nationality:_____**

**Country of Citizenship:**_____

**In order to provide optimal service and support, we need to ask some questions that will help us better understand the issues that you are facing or have been facing.**

**Did someone encourage you to come to counseling?** ☐ **Self** ☐ **Friend** ☐ **Instructor**

☐ **Advisor** ☐ **Provost** ☐ **Family member** ☐ **Center for Student Services** ☐ **Other**

**(specify)**_____

**Have you received counseling before?** ☐ **Yes** ☐ **No**

**If yes, please state the issue(s) addressed and the results of the counseling.**

_____

_____

_____

**Please describe what is troubling you (academic, social, personal, family):**

_____

_____

_____

**Approximately how long has this been of concern?**

☐ **Day** ☐ **Week** ☐ **Month** ☐ **Several Months** ☐ **Year** ☐ **Several Years** ☐ **Most of Life**

**What do you hope to achieve through counseling?** _____

_____

_____

**Have you or anyone else in your family ever been to counseling, or received medical treatment for a mental, emotional, or psychological problem?** _____

_____

_____

**Have you or anyone in your family been addicted to, or abused, any type of drug, alcohol, gambling, etc.?**

_____

_____

_____

**Are you currently taking any medications?**

_____

_____

**What level of social/emotional support does your family provide?**

☐**None** ☐**Minimal** ☐**Some** ☐**Much**

**What level of social/emotional support do your friends provide?**

☐**None** ☐**Minimal** ☐**Some** ☐**Much**

**What activities/organizations are you engaged in? _____**
**_____**

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**CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU**

| | | |
|---|---|---|
| **___poor appetite** | **___perfectionist** | **___depression** |
| **___trouble sleeping** | **___loss of weight** | **___crying spells** |
| **___ low self-esteem** | **___ decision making problems** | **___ lacking meaning in life** |
| **___suicidal thoughts** | **___lack of energy** | **___anxiety** |
| **___stomach trouble** | **___feeling inferior** | **___nightmares** |
| **___headaches** | **___worried** | **___impatient** |
| **___sexual identity** | **___can't make friends** | **___shy** |
| **___heavy caffeine use** | **___binge on food** | **___discrimination** |
| **___bad home conditions** | **___ alcohol or drug concerns** | **___street drugs** |
| **___guilt feelings** | **___can't concentrate** | **____unmotivated** |
| **___weight gain/body image** | **___dieting** | **___anger** |
| **___tobacco use** | **___feeling tired** | **___emotional swings** |
| **___academic concerns** | **___financial concerns** | **___panic attacks** |
| **___loneliness** | **___emotional/psychological abuse** | **___loss/grief/death** |
| **___ harassment** | **___legal concerns** | **___interpersonal concerns** |
| **___exposed to physical violence** | **___intimate relation concerns** | **___procrastination** |
| **___exposed to psychological violence** | **___exposed to sexual violence** | |

**Other _____**