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: _____

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? _____
_____

CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU

1. poor appetite	**18. perfectionist**	**35. depression**
2. trouble sleeping	**19. loss of weight**	**36. crying spells**
3. low self-esteem	**20. decision making problems**	**37. lacking meaning in life**
4. suicidal thoughts	**21. lack of energy**	**38. anxiety**
5. stomach trouble	**22. feeling inferior**	**39. nightmares**
6. headaches	**23. worried**	**40. impatient**
7. sexual identity	**24. can't make friends**	**41. shy**
8. heavy caffeine use	**25. binge on food**	**42. discrimination**
9. bad home conditions	**26. alcohol or drug concerns**	**43. street drugs**
10. guilt feelings	**27. can't concentrate**	**44. unmotivated**
11. weight gain	**28. dieting**	**45. body image**
12. tobacco use	**29. feeling tired**	**46. emotional swings**
13. academic concerns	**30. financial concerns**	**47. panic attack**
14. loneliness	**31. legal concerns**	**48. loss/grief/death**
15. harassment	**32. exposed to psychological violence**	**49. anger**
16. intimate relation concerns	**33. exposed to physical violence**	**50. chronic illness**
17. procrastination	**34. exposed to sexual violence**	**51. faith concerns**

Other _____