

Date _____

Name: _____ Gender: Male Female
Last First Mi

<input type="checkbox"/> I am a Student	Year in School	<input type="checkbox"/> Frosh	<input type="checkbox"/> Soph	<input type="checkbox"/> Jr	<input type="checkbox"/> Sr	<input type="checkbox"/> Grad
	Academic major _____	GPA _____		Hours enrolled _____		
	Place of employment _____		Work hours per week _____			
<input type="checkbox"/> I am Faculty/Staff	Position _____		Extension _____			

Rockhurst ID # _____ Date of Birth _____ Age _____ Ethnicity _____

Permanent Address _____ Phone _____
Street City State Zip

On Campus Address _____ Phone _____
Residence Hall & Room # Box #

Off Campus _____ Phone _____
Street City State Zip

Best Phone # to Reach You _____ If we need to contact you, may we leave a message? Yes No

In case of emergency (such as hospitalization, ER visit, suicide risk, or if the counselor is unable to reach you for an extended period), is there someone you give the Counseling Center permission to contact?

Name _____ Relationship _____ Phone 1 _____ Phone 2 _____

Relationship Status: Single Significant Other Married
 Separated Divorced Widowed

Living Situation: Specify _____
(For example: parent(s), spouse, friend, roommate, self, etc.)

How did you learn about the Counseling Center? _____

Who referred you? Self Faculty Academic Advisor
 Friend Parent RA/RD
 Health Services Student Services Other _____

OPTIONAL: I give my permission to the Rockhurst University Center to notify the following person who referred me. This notification is solely for the purpose of confirming my contact with the Rockhurst University Counseling Center:

Name of Referral Person _____ Phone _____
Your signature _____ Date _____

Are you presently receiving or seeking counseling from some person or agency other than this Center?
 Yes No With whom? _____

Have you received counseling services in the past?
 Yes No With whom? _____ When? _____ How long? _____

Have you been a client in the Rockhurst University Counseling Center?
 Yes No Previous Counselor _____

List any current or previous medication or physical conditions.

Do you have a disability?

Yes No

If YES, please describe _____

Do you have a personal primary health care provider?

Yes No

If YES, please list name& address _____

Date of last physical exam _____

What are the subjects of your concern?

(check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> My emotional well-being | <input type="checkbox"/> My relationship with others |
| <input type="checkbox"/> My academic performance | <input type="checkbox"/> My career/vocational plans |
| <input type="checkbox"/> My stress level | <input type="checkbox"/> My physical health |

What is the main concern you are bringing to counseling? (please be specific)

How much distress has this caused you in the past week, including today?

1	2	3	4	5
None	A little bit	Moderate	Quite a bit	Severe

How much is this concern interfering with your usual routine?

1	2	3	4	5
None	A little bit	Moderate	Quite a bit	Severe

How much is this concern interfering with your ability to perform academically?

1	2	3	4	5
None	A little bit	Moderate	Quite a bit	Severe

How much is this concern affecting you socially?

1	2	3	4	5
None	A little bit	Moderate	Quite a bit	Severe

What do you want to be different as a result of coming to counseling?

Brief Mood Survey *

(past week)

0--Not At All	1--Somewhat	2--Moderately	3--A Lot	4--Extremely
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Instructions: Put a check (✓) after each item to indicate how you have been feeling during the past week, including today. Please answer all the items.

Depression				
1. Sad or down in the dumps				
2. Discouraged or hopeless				
3. Low self-esteem				
4. Worthless or inadequate				
5. Loss of pleasure or satisfaction in life				

Please Total Your Score on Items 1 to 5 Here →

Suicidal Urges				
1. Do you have any suicidal thoughts?				
2. Would you like to end your life?				

Please Total Your Score on Items 1 and 2 Here →

Anxiety				
1. Anxious				
2. Frightened				
3. Worrying about things over and over				
4. Tense or on edge				
5. Nervous				

Please Total Your Score on Items 1 to 5 Here →

Panic				
1. Sudden feelings of terror or overwhelming fear				
2. Sudden, terrifying panic attacks that come out of the blue				
3. Suddenly feeling you're going crazy or cracking up				
4. Suddenly feeling you are about to suffocate or pass out				
5. Suddenly feeling you'll have a stroke, heart attack or die				

Please Total Your Score on Items 1 to 5 Here →

Anger				
1. Frustrated				
2. Annoyed				
3. Resentful				
4. Angry				
5. Irritated				

Please Total Your Score on Items 1 to 5 Here →

Relationship Satisfaction Scale *

Instructions: Place a check (✓) in the box that best describes how much satisfaction you feel in your closest relationship. Please answer all 5 items.

	0--very dissatisfied	1--moderately dissatisfied	2--somewhat dissatisfied	3--neutral	4--somewhat satisfied	5--moderately satisfied	6--very satisfied	
1. Communication and openness								
2. Resolving conflicts and arguments								
3. Degree of affection and caring								
4. Intimacy and closeness								
5. Overall satisfaction								
Please Total Your Score on Items 1 to 5 Here →								

OTHER POSSIBLE AREAS OF CONCERN

ACADEMIC

- Reduce test anxiety
- Improve study / test taking skills
- Improve time management

HEALTH and PERSONAL CONCERNS

- Weight change
- Eating pattern
- Body image
- Change in appetite
- Difficulty sleeping / sleeping too much
- Lack of energy – tired all the time
- Sexuality
- Concerns over use of drugs / alcohol / medicine
- Dealing with abuse
- Dealing with rape