

LANGSTON UNIVERSITY COUNSELING CENTER
CLIENT INFORMATION SHEET
110 & 111 University Women 405-466-3400

This information will be kept in your confidential record and used to facilitate the counseling process.

If a counselor needs to contact you, would you prefer:

- ☐ A non-identifying voicemail message ("This is Kenny, please call me at 466-3400.")
☐ A message identifying Counseling Center as the caller ("This is Kenny with the Counseling Center, please call me at 466-3400.")
☐ Please do not contact me.

☐ Home Phone (____) _____ ☐ Work Phone (____) _____
☐ Cell Phone (____) _____ ☐ Other Phone (____) _____

Last Name	First Name	MI	Today's Date
Campus Wide ID (CWID) #	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender	Age	Birthdate
Hometown(s): _____			
Campus/Local Address:		City/Zip Code	
Employed at _____ : hours per week _____			
What is your LU college? <input type="checkbox"/> Agriculture <input type="checkbox"/> Arts & Sciences <input type="checkbox"/> Business <input type="checkbox"/> Education <input type="checkbox"/> Nursing <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Graduate Education <input type="checkbox"/> Summer Programs <input type="checkbox"/> Nonstudent Military Veteran? <input type="checkbox"/> No <input type="checkbox"/> Yes-Current <input type="checkbox"/> Yes-Past	Class <input type="checkbox"/> Freshman <input type="checkbox"/> Sophomore <input type="checkbox"/> Junior <input type="checkbox"/> Senior <input type="checkbox"/> Graduate <input type="checkbox"/> Special Currently enrolled at: <input type="checkbox"/> LU <input type="checkbox"/> Not enrolled Credit hours enrolled in currently _____ Greek Affiliation? <input type="checkbox"/> Yes <input type="checkbox"/> No	Major: _____ Minor: _____ Cumulative GPA: _____ Transfer Student: <input type="checkbox"/> Yes <input type="checkbox"/> No Attend Class Regularly: <input type="checkbox"/> Yes <input type="checkbox"/> No Academic Probation: <input type="checkbox"/> Yes <input type="checkbox"/> No Student Athlete: <input type="checkbox"/> Yes <input type="checkbox"/> No	Ethnicity <input type="checkbox"/> African American/Black <input type="checkbox"/> Asian American <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic American <input type="checkbox"/> Native American <input type="checkbox"/> International student from _____ Other: _____ Affectional/Sexual Orientation <input type="checkbox"/> Gay/Lesbian <input type="checkbox"/> Bisexual <input type="checkbox"/> Heterosexual <input type="checkbox"/> Questioning/Uncertain <input type="checkbox"/> Prefer to not answer
Housing <input type="checkbox"/> Local/Off Campus <input type="checkbox"/> Campus Housing <input type="checkbox"/> Commuter Diagnosed Disability? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list: _____ _____	Relationship Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Partnered <input type="checkbox"/> Dating <input type="checkbox"/> Engaged <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Please indicate who referred you to the Counseling Center: <div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"><input type="checkbox"/> Self</div> <div style="width: 50%;"><input type="checkbox"/> Professor/Instructor/Faculty</div> <div style="width: 50%;"><input type="checkbox"/> Friend</div> <div style="width: 50%;"><input type="checkbox"/> Academic Advisor/University College</div> <div style="width: 50%;"><input type="checkbox"/> Parent/Family</div> <div style="width: 50%;"><input type="checkbox"/> Fraternity/Sorority</div> <div style="width: 50%;"><input type="checkbox"/> Residence Hall Staff</div> <div style="width: 50%;"><input type="checkbox"/> Coach/Trainer</div> <div style="width: 50%;"><input type="checkbox"/> Health Clinic</div> <div style="width: 50%;"><input type="checkbox"/> Personal Physician or Psychiatrist</div> <div style="width: 50%;"><input type="checkbox"/> Student Disability Services</div> <div style="width: 50%;"><input type="checkbox"/> Dean of Students</div> <div style="width: 50%;"><input type="checkbox"/> LU/Local Police</div> <div style="width: 50%;"><input type="checkbox"/> Other: _____</div> </div> Was the person who referred you a current or previous client at the SCC? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

Have you previously been a client at the Counseling Center? ☐ Yes ☐ No If yes, when? _____

If your name has changed since you were last seen at CC, please provide your former name: _____

Have you ever been in counseling or therapy or been hospitalized for mental health reasons? ☐ Yes ☐ No

If yes, when and where? _____

Have you ever taken medication(s) for mental health reasons? ☐ Yes ☐ No

If yes, what and when? _____

Please describe the concerns you would like to discuss with a counselor:

Please check all issues/concerns that you believe apply to your current situation:

- | | | |
|---|--|--|
| <input type="checkbox"/> Career/Major Indecision | <input type="checkbox"/> Body Image | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Relationships | <input type="checkbox"/> Eating Problems | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Family | <input type="checkbox"/> Sexual Assault/Rape | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Sexual Orientation | <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Academic Difficulty |
| <input type="checkbox"/> Alcohol/Drug | <input type="checkbox"/> Death of Family Member/Friend | |
| <input type="checkbox"/> Financial | <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Test or Performance Anxiety |
| <input type="checkbox"/> Adjustment to College | <input type="checkbox"/> Loneliness | <input type="checkbox"/> Reading/Study Skills |
| <input type="checkbox"/> Confusion about Beliefs | <input type="checkbox"/> Perfectionism | <input type="checkbox"/> Religious/Spiritual |
| <input type="checkbox"/> Dating Concerns | <input type="checkbox"/> Physical Health Problems | <input type="checkbox"/> Self-Esteem/Self-Confidence |
| <input type="checkbox"/> Independence from Family | <input type="checkbox"/> Pregnancy Related | <input type="checkbox"/> Sexual Concerns |
| <input type="checkbox"/> Ethnic/Racial Discrimination | <input type="checkbox"/> Procrastination/Time management | |
| <input type="checkbox"/> Anger, Irritability, Hostility | <input type="checkbox"/> Other _____ | |

Please check current symptoms:

- ☐ Suicidal Feelings
☐ Difficulty Concentrating
☐ Difficulty Sleeping
☐ Frequent Tiredness
☐ Lack of Motivation
☐ Changes in Appetite
☐ Other _____

Please indicate the seriousness of the concerns with which you are dealing:

	1	2	3	4	5	6	7	
Not very serious	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Very serious, I am in crisis

Please list your immediate family members and extended family members with whom you are close:

Name & Age	Relationship	Occupation
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

In the event of an emergency, is there someone we have your permission to contact?

Name: _____ Relationship: _____

Phone number: Home (____) _____ - _____ Cell (____) _____ - _____ Work (____) _____ - _____