



PERSONAL INFORMATION FORM

Name: _____

Today's Date: _____

Birth Date: ___/___/___ Age: _____

Gender: Male Female Other (please specify) _____

How did you hear about the counseling center? : _____

Your Current Address:

(Street and Number) (City) (State) (Zip)

Best Phone Number to Reach You: _____

May I leave a msg? Yes No

E-mail: _____

May I email you? Yes No

*Please be aware that email might not be confidential.

Marital Status: Never Married Partnered Married Separated Divorced Widowed

Ethnicity (check all that apply):

- African/American
- East Indian/Pakistani
- Korean/Korean-American
- Native American
- White/Caucasian
- Chicano/Mexican-American/Puerto Rican
- Filipino
- Latino/Latino American/Hispanic
- Polynesian/Micronesian
- Other (specify _____)
- Chinese/Chinese American
- Japanese/Japanese American
- Middle Eastern
- Vietnamese

Religious/Spiritual Background: _____

Decline to answer

Sexual Orientation: _____

Decline to answer

Program of Study: (check one)

- BSN
- ABSN (Which campus? _____)
- ELMSN- CM
- ELMSN- FNP
- MSN-FNP (Advanced Practice)
- MSN-CRNA
- MOT
- MPA
- DPT
- DPM

Current Year in Program: _____

Expected Graduation Date: _____

G.P.A: _____

Emergency Contact: **MUST COMPLETE

Name: _____

Relationship: _____

Address: _____

Phone: _____

Do you live on or off campus?

On-campus Off-campus

With whom do you live? (check all)

- Alone
- Spouse, partner, significant other
- Roommate(s)
- Children
- Parent(s)/Guardian(s)
- Family other

SOCIAL & ROMANTIC RELATIONSHIP HISTORY

1. Currently, how would you rate the quality of your **peer/social relationships**?

- Very Poor Unsatisfactory About Average Good Excellent

2. Outside of family members, approximately how many people can you count on for **friendship/emotional support**? _____

3. Are you currently in a **significant intimate/romantic relationship**? Yes No Unsure For how long? _____

4. Have you **ever been** in an abusive relationship (physical, sexual, emotional (control, manipulation), verbal?) Yes No

5. Are you **currently experiencing** abuse in your relationship? Yes No

Describe: _____

EDUCATIONAL BACKGROUND

Educational History	Dates Attended	Date Graduated	Degree Earned	GPA
Name of School (include city, state) <i>*starting with High School</i>				

Have you ever experienced **learning problems** in elementary, high school or college? No Yes

If yes, please describe: _____

Do you have a **diagnosed and/or documented disability**? No Yes

If yes, please describe: _____

HEALTH HISTORY

1. **How is your physical health at present?** Poor Unsatisfactory Satisfactory Good Very Good

2. **Please list any persistent physical symptoms or health concerns** (e.g. chronic pain, allergies, headaches, hypertension, diabetes, etc) _____

3. **Are you presently taking any prescribed medication (non psychiatric)?** No Yes

If yes, please indicate medication type, dosage and reason for use:

4. **Are you having any problems with your sleep habits?** No Yes (If yes, check where applicable):

Sleeping too little Sleeping too much Early Waking

Poor Sleep Quality Disturbing dreams Other _____

5. **Have you had any recent (past 1-3 weeks) changes in your energy level?** No Yes

- Less energy than usual
- More energy than usual
- Energy about the same

6. **Have you had any recent (past 1-3 weeks) changes with your appetite?** No Yes

- Eating less than usual
- Eating more than usual
- Significant weight change in last 2-3 months (+ or -)? How much? _____

7. **Are you having any difficulty with eating habits?**

- Binge Eating
- Purging (i.e., vomiting, laxatives, enemas, etc.)
- Food restriction

No Yes If yes, please check all that apply

- Excessive/compulsive exercise
- Chronic Dieting
- Other _____

8. **How often do you drink alcohol** (frequency per week)? _____

How much do you drink (quantity and type)? _____

Do you consider your alcohol consumption a problem? No Yes Unsure

9. **Do you use recreational drugs?** No Yes (If yes, please check all that apply and indicate frequency):

- Tobacco Opiates Tranquilizers/sedatives
- Marijuana Cocaine Inhalants
- Hallucinogens Stimulants

10. **Do you have any problems or worries about sexual functioning?** No Yes (If yes, check where applicable):

- Lack of desire Difficulties maintaining arousal
- Performance Problem Worried about sexually transmitted disease
- Sexual Impulsiveness Other _____

FAMILY BACKGROUND

1. Please list the **members** of your current family (include ages, occupations, marital status, & education)

	Relationship	Marital Status	Living or Deceased	Age	Sex	Occupation	Educational Level
Family of Origin	Parent 1						
	Parent 2						
	Parent 3						
	Parent 4						
Current Family	1st Sibling						
	2nd Sibling						
	3rd Sibling						
	4th Sibling						
Current Family	Spouse/ Partner						
	1st Child						
	2nd Child						
	3 rd Child						

2. Please check any **past, present, or impending** special problems ***in your family of origin:***

- | | | |
|---|--|--|
| <input type="checkbox"/> deaths | <input type="checkbox"/> alcohol/drug abuse | <input type="checkbox"/> legal problems |
| <input type="checkbox"/> divorce | <input type="checkbox"/> serious illness | <input type="checkbox"/> attempted/completed suicide |
| <input type="checkbox"/> frequent relocations | <input type="checkbox"/> psychiatric disorder | <input type="checkbox"/> eating disorders |
| <input type="checkbox"/> debilitating injuries/disabilities | <input type="checkbox"/> physical/sexual abuse | <input type="checkbox"/> other _____ |
| | <input type="checkbox"/> financial crisis/unemployment | |

3. Have you personally experienced significant ***family abuse in the past?***

- | | | |
|------------------------------------|-----------------------------------|--|
| <input type="checkbox"/> none | <input type="checkbox"/> verbal | <input type="checkbox"/> decline to answer |
| <input type="checkbox"/> unsure | <input type="checkbox"/> physical | |
| <input type="checkbox"/> emotional | <input type="checkbox"/> sexual | |

4. Do any **psychological difficulties** run in your family? *****please check all that you are aware of OR suspect***

	Self	Mother	Father	Siblings	Maternal Grand Mother	Maternal Grand Father	Paternal Grand Mother	Paternal Grand Father	Aunts	Uncles
Depression										
Suicide (attempt or completed)										
Anxiety										
Obsessive Compulsive Disorder										
Bipolar Disorder										
Eating Disorder										
Psychosis/Delusional Disorders										
ADD/ADHD										
Alcoholism and/or Drug Addiction										
Hospitalization for Mental Health										
Medications for Mental Health										
Other (please indicate)										

PERSONAL MENTAL HEALTH HISTORY

Are you **currently receiving** psychiatric services, professional counseling or psychotherapy elsewhere? Yes No

If yes, please indicate where and with whom: _____

Have you **had previous** psychological counseling? No Yes

***** If yes, please fill out chart***

Dates of Past Counseling	Approx. # of Sessions attended	Where Received Counseling & Name of Provider	Your Age at that Time	Reasons for seeking counseling at that time

What, if any, mental or psychological conditions have you previously been diagnosed with?

Have you experienced significant deaths or losses in your life (e.g. parent, sibling, friend, divorce, break-up, etc.)?

_____ Year _____
Year _____
Year _____

Have you experienced a traumatic event(s), recent or past? If so, please specify (e.g. sexual assault/rape; physical assault; child abuse; dangerous car accident; severe illness; combat/military experience; witnessed or experienced life threatening event; natural disaster, etc):

_____ Year _____
Year _____
Year _____

Are you CURRENTLY TAKING prescribed psychiatric medication (antidepressants or others)? Yes No

If yes, please fill out chart indication the psychiatric medications you currently take

Medication Type	Dosage/Day	How long have you been taking this medication?	Reason for taking medication?

If not currently taking, have you PREVIOUSLY TAKEN prescribed psychiatric medication? Yes No

If yes, please fill out chart

Medication Type	Dosage/Day	How long did you take this medication (dates)?	Reason for taking medication?

Please indicate if you experience any of the following (recent or past):

1. **Have you had thoughts of suicide recently (last few days, weeks, months)?** Yes No
If yes, have you considered a plan? Yes No
If yes, would you describe the thoughts as mild, moderate or severe? _____
2. **Have you had suicidal thoughts in the past?** Yes No
If yes, when? _____
3. **Have you ever seriously considered attempting suicide?** Yes No
If yes, when? _____
Did you have a plan? Yes No
4. **Have you ever attempted suicide?** Yes No
If yes, when? _____
Method of attempt? _____
5. **Do you have a history of self-injury without suicidal intent (e.g. cutting, burning, hair pulling, hitting, etc.)** Please describe _____ Yes No
6. **Have you ever been hospitalized for mental health concerns?** Yes No
If yes, when? _____
Where? _____
For what reason? _____
7. **Heard voices or seen things that were not really there?** Yes No
If yes, please describe _____

Client Signature: _____

Date: _____

Counseling Services
3100 Telegraph Avenue, Suite #1000
Oakland, CA 94609
(510) 869-1516

CONCERNS CHECKLIST

What concerns are bringing you to seek counseling at this time?

Abuse Issues (past or current)

- Emotional abuse
- Physical abuse
- Sexual abuse
- Verbal Abuse
- Child Abuse
- Relationship Abuse

Control & Substance Issues

- Alcohol (beer, wine, or liquor)
- Cocaine, speed, ecstasy, Rx drugs, etc
- Marijuana use
- Gambling
- Internet addiction
- Other addiction: _____

Emotional Concerns

- Anger
- Anxiety, fears or phobias
- Depression
- Guilt
- Isolation, withdrawal
- Mood swings
- Nervousness
- Self-control
- Stress
- Suicidal thoughts
- Worry

Social or Performance Concerns

- Decision making or setting goals
- Difficulty concentrating
- Shyness/discomfort in social settings
- Lack of assertiveness
- Lack of motivation
- Loneliness
- Memory problems
- Test taking Anxiety
- Public speaking anxiety

Harassment Problems

- Racial/ Ethnic
- Sexual
- Sexual orientation
- Being stalked

Violence issues

- Acquaintance/Date rape
- Relationship violence
- Sexual assault
- Stranger rape

Life circumstances

- Financial matters
- Death, grief, loss, separation
- Credit card debt
- Legal problems
- Life Transitions (marriage, divorce, pregnancy, leaving home, midlife, etc.)
- Illness of someone close

Personal Issues

- Struggles with self-esteem/ self confidence
- Confusion about values, morals, beliefs
- Loss of faith in my religion/religious uncertainty
- Cultural conflict/adjustment
- Concern about coming out (sexual orientation)
- Generation gap/Acculturation issues
- Sexual concerns

Relationship Issues

- Family members (parents, children, siblings, etc)
- Interracial dating
- Interreligious dating
- Parenting concerns
- Partner /spouse
- Peer relationships
- Relationship breakup or divorce
- Sexual Concerns

- Academic/Career Concerns** (describe)

- Health Problems** (describe)

- Sleep Problems** (describe)

- Other** (describe)

****What is the primary reason(s) you are seeking counseling at this time:** (please describe)

