Ohio Wesleyan University Counseling Services
HWCC Room 324

CONFIDENTIAL INTAKE DATA SHEET

Name:_____ Date:_____ ID#_____

Campus Address:_____ Box:_____ **Cell:** _____

Home Address:_____ Home Phone:_____

City: _____ State:_____ Zip Code: _____

Age:_____ Date of Birth:_____ Gender: _____ Gender Pronoun: _____

Sexual Orientation *(Optional)*: _____

Ethnicity / Nationality:
__African American / Black __Anglo American / White __Asian American / Pacific Islander

__Hispanic American / Latino __International_____

__More than One Ethnicity_____ __Native American
(*Please Specify)*

__Other_____
(*Please Specify)*

Relationship Status: _____

1st Generation College Student: __Yes __ No

Year in school: __Freshman __Sophomore __Junior __Senior __Other

Major:_____ **GPA:**_____ **Career Objective:**_____

How many classes are you enrolled in:_____ Are you on academic probation __Yes __No
Are you a transfer student __Yes __No If yes, name of former school:_____
Are you currently employed __Yes __No If yes, how many hours per week:_____

If Counseling Services would need to contact you, is it okay to:
Call cell phone __Yes __No
Leave a voice message __Yes __No
E-mail __Yes __No E-mail address: _____
Permission to send text reminder __Yes __No

How did you learn about Counseling Services:
__Self-referral __Friend __Faculty __Residence Hall Staff (RA/RLC)
__Academic Advisor __Family Member __OWU Daily __Student Health Services
__HelpLine __Brochure __Other_____

Does the problem which led you to counseling interfere with your ability as a student? __Yes __ No

Medical Information:
Current medical condition/health concerns:_____
Current medications:_____
Have you been to the hospital for any emotional or mental health concerns? __Yes __No When?_____
Have you received treatment for alcohol or other drug abuse? __Yes __No When?_____

Briefly describe the concerns that led you to request an appointment at this time:

_____

_____

_____

_____

** *Please complete* ***FRONT and BACK*** of this form

*Check **ONLY** those areas that apply to you:*

Academic concerns / Grades		**Impulse control**	
Adjustment to the University		**Legal matters**	
Alcohol / or other Drug use (yourself or another)		**Loneliness**	
Anger Management		**Loss / grief**	
Anxiety, worries		**Motivation**	
Assertiveness		**Oppression / Discrimination**	
Body Image / Weight control		**Perfectionism**	
Career concerns		**Persistent lack of energy**	
Choosing a major		**Persistent unhappiness**	
Chronic health concerns		**Persistent numbness**	
Concentration		**Pregnancy concern**	
Concern for a friend		**Problems with faculty/staff**	
Death and Dying		**Relationship (s) with friend (s)**	
Difficulty making decision (s)		**Repetitive thoughts or behaviors**	
Disabilities		**Romantic relationship (s)**	
Dissatisfaction / Loss of interest in things		**Roommate concerns**	
Family		**Self-harm / self-injury**	
Finances		**Self-esteem, self-concept**	
Food / Appetite concerns		**Sexual matters**	
Guilt / Shame		**Sleep problems**	
Homesick		**Sudden changes in personality or behavior**	
Homicidal thoughts		**Suicidal thoughts**	
Hopelessness		**STI's**	
Identity exploration (circle choices): **Gender** **Sexuality** **Religious / spiritual** **Or other: _____**		**Uncomfortable in social situations**	
		Unhappiness	
OTHER:			

Please write down your top 3 from the survey above:

Have you been in counseling before? If yes, please describe.

How long have these issues been bothering you?

What would you like to accomplish in counseling?

How many counseling sessions do you anticipate needing? _____

Please give any additional information which you believe might be relevant to your concerns and counseling.