



*To help us address your needs and concerns, please complete a separate questionnaire for each person participating in therapy. Please answer honestly; all information will be kept confidential.*

**For children under 12:** 1) parent(s) complete a questionnaire for themselves and answer all questions as they pertain to you, not your child; 2) please fill out **only the first two pages** of a separate questionnaire as they pertain to your child.

### ***Client Information***

**Name:** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Primary Phone:** \_\_\_\_\_ (Home, Work, or Cell?) **Leave message:** \_\_Y\_\_N

**Alternate Phone:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Gender:** \_\_\_\_\_ Male \_\_\_\_\_ Female **Ethnicity:** \_\_\_\_\_

**Status:** \_\_Married \_\_Single \_\_Divorced \_\_Widowed \_\_Separated \_\_Partnered

\_\_\_\_Other (specify) \_\_\_\_\_ **Years in Relationship:** \_\_\_\_\_

#### **Client is:**

\_\_\_\_TTUHSC Student \_\_\_\_Spouse of HSC Student \_\_\_\_Child of HSC Student \_\_\_\_Other (list) \_\_\_\_\_

\_\_\_\_Employee \_\_\_\_Spouse of Employee \_\_\_\_Child of Employee \_\_\_\_Other (list) \_\_\_\_\_

#### **Family Members (in household):**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_

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Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_

**Previous Client?** \_\_\_\_Yes \_\_\_\_No If yes, counselors name: \_\_\_\_\_

**How did you learn about the Counseling Center?** \_\_\_\_\_

**Were you mandated to receive counseling?** \_\_\_\_Yes \_\_\_\_No

**In case of emergency, whom should we contact?**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**Primary Physician:** \_\_\_\_\_

Please list **ALL MEDICATIONS** you are taking below, *including non-prescription medications*:

Name of Medication	Dosage	Prescribing Doctor	When Began	Reason Taking

***Benefit Information***

*Please provide information for **the person with EAP or PAS benefits**. If more than one person in the household has benefits, please check that program as well.*

**EAP Program:**

<input type="checkbox"/> TTU	<input type="checkbox"/> PYCO Industries	<input type="checkbox"/> UMC
<input type="checkbox"/> TTUHSC	<input type="checkbox"/> Shallowater ISD	<input type="checkbox"/> UMC Physicians
<input type="checkbox"/> Citibus	<input type="checkbox"/> Shropshire Agency	<input type="checkbox"/> United Way Agency
<input type="checkbox"/> City of Lamesa	<input type="checkbox"/> Slaton ISD	(Communities in Schools, WPS, Catholic
<input type="checkbox"/> City of Lubbock	<input type="checkbox"/> South Plains College	Family Services, Legal Aid,
<input type="checkbox"/> Lubbock Cooper ISD	<input type="checkbox"/> South Plains Electric	BB-BS, Casa)
<input type="checkbox"/> LISD	<input type="checkbox"/> Standard Sales	
<input type="checkbox"/> Poka Lambro	<input type="checkbox"/> TT Federal Credit Union	

**Status:** ☐ *Full Time* ☐ *Part Time* ☐ *Other*

**Years Employed:** \_\_\_\_\_

**PAS Program:**

<input type="checkbox"/> School of Medicine	<input type="checkbox"/> School of Health Professions
<input type="checkbox"/> School of Pharmacy	<input type="checkbox"/> Graduate School of Biomedical Sciences
<input type="checkbox"/> School of Nursing	

**Status:** ☐ *Full Time* ☐ *Part Time* ☐ *Other*

**Years in Program:** \_\_\_\_\_

## *Client Wellness*

**Current Concerns:** What problem(s) do you want help with in counseling? For each problem you identify, please state *when the problem began* and *how distressed* you have been by that problem.

Concern	When began?	A little	Moderate	Quite a bit	Extremely
1.		1	2	3	4
2.		1	2	3	4
3.		1	2	3	4

**Range of Problems:** In the past month, how **troubled** were you by each of the following (*circle the number*):

	Not at all	A little bit	Moderately	Quite a bit	Extremely
Medical Problems	0	1	2	3	4
Employment Problems	0	1	2	3	4
Family Problems	0	1	2	3	4
Psychological or emotional Problems	0	1	2	3	4
Legal Problems	0	1	2	3	4
Financial Problems	0	1	2	3	4
Alcohol Problems	0	1	2	3	4
Drug Problems	0	1	2	3	4
Tobacco use Problems	0	1	2	3	4
Chronic Pain Issues	0	1	2	3	4
Weight Issues	0	1	2	3	4
Suicidal Thoughts	0	1	2	3	4
Thoughts of harming someone else	0	1	2	3	4

**Life Satisfaction:** At the present time, how satisfied are you with these areas of your life (*circle the number*):

	Extremely Dissatisfied	Dissatisfied	Somewhat Dissatisfied	Somewhat Satisfied	Satisfied	Very Satisfied
Work and/or Studies	1	2	3	4	5	6
Leisure time activities	1	2	3	4	5	6
Love and intimate relationships	1	2	3	4	5	6
Other Interpersonal relationships	1	2	3	4	5	6
General sense of happiness	1	2	3	4	5	6
Progress towards personal goals	1	2	3	4	5	6

**Behavioral Health:**

Do you drink alcohol? \_\_\_Yes \_\_\_No    If yes, what do you drink? \_\_\_\_\_

How often do you drink? \_\_\_\_\_ How much? \_\_\_\_\_

Do you drink more than you use to? \_\_\_Yes \_\_\_No

Has anyone objected to your drinking? \_\_\_Yes \_\_\_No

Do you use drugs? \_\_\_Yes \_\_\_No    If yes, which drug(s) do you use? \_\_\_\_\_

How often do you use drugs? \_\_\_\_\_ How much? \_\_\_\_\_

Do you use drugs more now than you use to? \_\_\_Yes \_\_\_No

Has anyone objected to your drug use? \_\_\_Yes \_\_\_No

Have you ever struggled with an eating disorder (*anorexia, bulimia, etc.*)? \_\_\_Yes \_\_\_No \_\_\_Not sure

If yes, which one(s)? \_\_\_\_\_ When? \_\_\_\_\_ How long? \_\_\_\_\_

Have you ever engaged in self-harm (*cutting, burning, etc.*)? \_\_\_Yes \_\_\_No

If yes, what kind(s)? \_\_\_\_\_ When was last occurrence? \_\_\_\_\_

**Who do you consider to be in your support system? (please check all that apply)**

\_\_\_spouse/partner    \_\_\_immediate family    \_\_\_extended family    \_\_\_close friend    \_\_\_group of friends

\_\_\_faith group    \_\_\_12 step program    \_\_\_other (*specify*) \_\_\_\_\_

**To complete this intake please provide a photo ID at your first visit or email a copy of your photo ID to [counselingcenter@ttuhsc.edu](mailto:counselingcenter@ttuhsc.edu) (Parents ID should be provided for anyone under 18).**