SPRING HILL
1830
COLLEGE

GENERAL INFORMATION

PLEASE TAKE A MOMENT TO ANSWER THE FOLLOWING QUESTIONS. THIS INFORMATION WILL BE KEPT IN YOUR CONFIDENTIAL FILE AND WILL BE USED TO FACILITATE THE COUNSELING PROCESS.

TODAY'S DATE:			
FIRST NAME:		LAST NAME:	
BIRTH DATE:	AGE:	GENDER:	
HOME TOWN & STATE:			
LOCAL ADDRESS:			
CITY & STATE:	ZIP:	EMAIL:	
YEAR IN SCHOOL:	MAJOR OR PROGRAM:	PHONE: ( )	
WHERE YOU REFERRED TO THE WELLNESS CENTER? _____ IF YES, WHO REFERRED YOU: _____			
MAY WE CALL IF NECESSARY? _____	MAY WE LEAVE A MESSAGE? _____		
EMERGENCY CONTACT: ON CAMPUS: _____ OFF CAMPUS: _____			
PLEASE PROVIDE US WITH SOME INFORMATION ABOUT YOUR FAMILY. INCLUDE ALL SIGNIFICANT FAMILY MEMBERS.			
NAME:	RELATIONSHIP:	AGE:	
NAME:	RELATIONSHIP:	AGE:	
NAME:	RELATIONSHIP:	AGE:	

Have you ever received counseling?	☐ Yes	☐ No	☐ Uncertain
If yes, was it at the Wellness Center?	☐ Yes	☐ No	☐ Uncertain
Do you have any legal issues?	☐ Yes	☐ No	☐ Uncertain
Have you had any recent thoughts of harming yourself or thoughts of suicide?	☐ Yes	☐ No	☐ Uncertain
Have you had any thoughts of harming others?	☐ Yes	☐ No	☐ Uncertain

PLEASE CHECK ALL THAT APPLY:

- ☐ **RELATIONSHIP DIFFICULTES**: Break up/loss of relationship, problems with romantic partner/spouse, relationships with family, friends, or roommates
- ☐ **CAREER UNCERTAINTY**: Unclear career path, lack of knowledge about interests and/or abilities
- ☐ **SELF-ESTEEM ISSUES:** Concerns about self-image and/or shyness
- ☐ **EXISTENTIAL CONCERNS**: Searching for meaning in life and/or concern about religion's role in life
- ☐ **ACADEMIC CONCERNS:** Grades or school related work
- ☐ **DEPRESSION:** Low self-esteem, feelings of hopelessness, suicidal thoughts, and/or grief over loss/death
- ☐ **ANXIETY:** Fear, nervousness, performance anxiety, phobias, and/or panic attacks
- ☐ **EATING DISORDERS**: Bulimia, anorexia, body image concerns, compulsive eating
- ☐ **SUBSTANCE ABUSE**: Drugs and/or alcohol
- ☐ **SEXUAL ABUSE OR HARASSMENT:** Rape, incest, harassment, and/or being obsessively pursued
- ☐ **SEXUAL IDENTITY:** Confusion and/or questions about sexual orientation
- ☐ **STRESS AND PSYCHOSOMATIC SYMPTOMS:** Headaches, stomach pains, and/or sleep disturbances
- ☐ **SEXUALITY ISSUES:** Any concern related to sexual behavior
- ☐ **ANGER MANAGEMENT**
- ☐ **ANYTHING ELSE WE SHOULD KNOW ABOUT:** _____

_____

HISTORY	**Yes**	**No**	**Uncertain**
Any history of alcoholism and/or chemical dependency in your family?			
Any history of mental illness in your family?			
Have you ever been physically abused?			
Have you ever been emotionally abused?			
Have you ever been sexually assaulted or abused?			

PLEASE INDICATE THE LEVEL OF CONCERN YOU CURRENTLY FEEL:

NONE *VERY SERIOUS*

1 2 3 4 5 6 7 8 9 10

Please sign and date to verify that all information provided is accurate.

_____ _____

Signature: Date: