

Duquesne University Counseling Center
Client Intake Form

*Please complete and bring this form to your first appointment. **Please print.*** Date _____

Name _____ Date of Birth _____ SSN(last 4 digits) _____ Sex _____

Phone _____ May we call and leave a voicemail message? Yes No

Address/ Name of Residence Hall _____ SMC# _____

City _____ State _____ Zip _____ May we send mail? Yes No

E-mail Address _____ May we send email? Yes No

Permanent address _____

Permanent phone _____ May we contact you with this address/phone? Yes No

Who may we contact in case of emergency? _____ Phone _____

Emergency contact's relationship to you _____

Academic School _____ Academic Major _____

Year in School _____ Cumulative GPA _____ Last Semester GPA _____

Who referred you to the UCC? ___ Self ___ Friend ___ Family ___ Professor ___ Health Service
___ Academic Advisor ___ Residence Life ___ Campus Ministry ___ Other: _____

May the UCC tell the person who referred you that you came? ___ Yes ___ No Initials: _____

Have you previously been in therapy? Yes No

If yes, with whom? When? _____

Are you currently under a physician's care? Yes No

If yes, with whom? Purpose? _____

Please list any medications you are taking, the dosage, and what the medication is for: _____

What is the name of your health insurance plan? _____

How would you describe your general mood/feelings? _____

How many sessions might you expect to complete? 1 2 3 4 5 6 7 8 9 10 11 12 13+ no idea

Please briefly describe your reason(s) for seeking treatment. What do you hope to gain by coming to the University Counseling Center?

Please provide the following information about family and significant others:

Name	Age (if living)	Occupation
Parents _____		
and/or _____		
Step- _____		
Parents _____		

Siblings _____		

Significant _____		
Other _____		
Children / Others _____		
in the home _____		

Do you have a religious/spiritual affiliation? Yes No If yes, please describe: _____

How do you identify yourself ethnically? _____

How do you identify your sexual orientation? _____

Do you or your family have financial issues or worries? _____

In general, how would you rate your physical health? (very unhealthy) 1 2 3 4 5 6 7 (very healthy)

Do you sleep well and feel rested upon waking? _____

Do you exercise regularly? Yes No If yes, please describe: _____

How do you spend your leisure time? (sports, hobbies, social organizations...) _____

How satisfied are you with your friendships/relationships? (dissatisfied) 1 2 3 4 5 6 7 (satisfied)

In general, how do you feel about yourself? (very uncomfortable) 1 2 3 4 5 6 7 (very comfortable)

Please list three things that you really like about yourself.

1. _____
2. _____
3. _____