REGENT UNIVERSITY
1000 Regent University Drive, Virginia Beach, VA 23464-9800

Christian Leadership to Change the World

Student Counseling Services

CLIENT INFORMATION FORM

Date: _____

PERSONAL INFORMATION

Name: _____ Date of Birth: _____

Gender: _____ Ethnicity: _____ Marital Status: _____

Local Address: _____

City: _____ State: _____ Zip: _____

Permanent Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

OTHER MEMBERS OF HOUSEHOLD:

NAME	AGE	RELATIONSHIP

EDUCATIONAL / ACADEMIC INFORMATION

Please indicate: ☐ Undergraduate Major: _____ GPA: _____ Graduation Date: _____

☐ Graduate Major: _____ GPA: _____ Graduation Date: _____

Describe any school-related concerns you have at this time:

_____

_____

EMPLOYER / OCCUPATIONAL INFORMATION

Employer: _____ Position: _____

Date of Hire: _____ Salary: _____

Level of Satisfaction with Current Job: ☐ Highly Satisfied ☐ Satisfied ☐ Dissatisfied

Explain: _____

_____

_____

MEDICAL DATA & HISTORY

What is your present state of health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

When were you last seen by a physician? _____ Name: _____ Reason: _____

When did you receive your last physical? _____

Who is your Primary Care Physician? _____

Address: _____

City: _____ State: _____ Zip: _____

Office Phone: ( ) _____ Fax: ( ) _____

Please list any current medical conditions you may have.

_____

_____

_____

Please list any medications (prescribed or over-the-counter) that you are currently taking.

Name	Dosage	Reason	Prescribed By

Were there any problems during your mother's pregnancy with you or at your birth? If so, please describe.

_____

_____

_____

_____

Were there any problems during your development, such as delayed walking, talking, or problems relating to others? If so, please describe.

_____

_____

_____

_____

Please list any major illnesses, injuries, surgeries, and/or hospitalizations you have had and your age at the time.

_____

_____

_____

Please list any allergies you have (food, drugs, environmental, etc.).

_____

If you have suffered a head injury, please describe the incident.

_____

_____

_____

Date of the Incident: _____ Loss of Consciousness? _____ How Long? _____

Aid you have amnesia of events before the incident? _____ After? _____

Do you remember the incident itself: _____ Were you treated by a doctor? _____ Hospitalized? _____

Please indicate all of the following that have occurred in your family and identify which family member(s).

- ☐ Cancer _____
- ☐ Tuberculosis _____
- ☐ Diabetes _____
- ☐ Heart Trouble _____
- ☐ Stroke _____
- ☐ Epilepsy _____
- ☐ Alcoholism _____
- ☐ High Blood Press. _____
- ☐ Mental Illness _____
- ☐ Suicide _____
- ☐ Drug Abuse _____

ALCOHOL / SUBSTANCE USE

I use or have used the following (check all that apply).

	USED IN LAST 48 HOURS	USED IN LAST MONTH	HAVE USED BEFORE
Caffeine (Coffee, Tea, Cola)			
Pep Pills Or Uppers			
Alcohol			
Tranquilizers Or Sedatives			
Diet Pills			
Marijuana			
LSD Or Other Hallucinogens			
Cocaine			
Nicotine			
Other: _____			
Other: _____			

Please complete the following sentences, filling the name of the drugs used most often.

I Use _____

- ☐ Once Per Month
- ☐ Once Per Week
- ☐ More than Once Per Week
- ☐ Daily
- ☐ Several Times Daily

I Use _____

- ☐ Once Per Month
- ☐ Once Per Week
- ☐ More than Once Per Week
- ☐ Daily
- ☐ Several Times Daily

I Use Alcohol:

- ☐ Never
- ☐ Once Per Month
- ☐ Once Per Week
- ☐ More than Once Per Week
- ☐ Daily
- ☐ Several Times Daily

Do you (or others) think you now have a problem with any of the substances you checked above? ☐ No ☐ Yes
If "yes", please specify the substance(s) and state who thinks so:

_____

_____

_____

Please check any of the following which have happened to you while using alcohol, drugs, or medications.

	ALCOHOL	DRUGS	MEDICATION
I have lost consciousness or didn't know what was happening.	☐	☐	☐
I have had a fit or convulsion.	☐	☐	☐
I have been hospitalized for	☐	☐	☐
I have had other treatment for	☐	☐	☐

FAMILY & SOCIAL DATA/HISTORY

Did either of your parents die during your childhood or adolescence?

- ☐ No
- ☐ Yes: My mother died when I was _____ years old.
- ☐ Yes: My father died when I was _____ years old.
- ☐ Unknown

Check all the persons with whom you lived while growing up and indicate your relationship with them at the time.

	Good	Fair	Poor
☐ Natural Mother	☐	☐	☐
☐ Natural Father	☐	☐	☐
☐ Stepmother	☐	☐	☐
☐ Stepfather	☐	☐	☐
☐ Adoptive Parents	☐	☐	☐
☐ Foster Parents	☐	☐	☐
☐ Brothers (list)	☐	☐	☐
_____	☐	☐	☐
	☐	☐	☐

	Good	Fair	Poor
☐ Sisters (list)	☐	☐	☐
_____	☐	☐	☐
_____	☐	☐	☐
☐ Others (list)	☐	☐	☐
_____	☐	☐	☐
_____	☐	☐	☐
_____	☐	☐	☐
_____	☐	☐	☐

As a child, were you abused? ☐ Yes ☐ No (if yes, please explain)

_____

_____

_____

Please check any of the following which describe the atmosphere in your home when you were a child.

☐ Trusting	☐ Happy	☐ Quarreling
☐ Unhappy	☐ Rigid	☐ Understanding
☐ Loving	☐ Secure	☐ Insecure
☐ Cold	☐ Casual	

When you were a child did you participate in school activities, church activities, or clubs?

☐ Yes, many ☐ Yes, few ☐ None

Please check any of the following which describe you as a child.

☐ Nightmares	☐ Temper Tantrums	☐ Bed Wetting
☐ Nail Biting	☐ Insomnia	☐ Thumb Sucking
☐ Speech Problems	☐ Stealing	☐ Fire Setting
☐ Daydreaming	☐ Running Away	☐ Lying
☐ Cruelty to Animals	☐ Bullying	☐ Loneliness
☐ Picked on	☐ Sleepwalking	☐ Head Banging

List the people with whom you now live and check the box which best describes your relationship with them.

NAME	RELATIONSHIP	GOOD	FAIR	POOR
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐

List your family members who no longer live with you and check the box which best describes your relationship with them.

NAME	RELATIONSHIP	GOOD	FAIR	POOR
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐

I began going on dates when I was _____ years old.

I became interested in sex:

- ☐ Before age 12
- ☐ Between ages 12 and 16
- ☐ Between ages 16 and 20
- ☐ After age 20
- ☐ Never interested

I would classify my sexual preference as:

- ☐ Heterosexual (prefer opp. sex)
- ☐ Homosexual (prefer same sex)
- ☐ Bisexual (prefer either sex)
- ☐ Other (specify) _____

Before I got married I dated or was interested in:

- ☐ Many boys / girls
- ☐ A few boys / girls
- ☐ Only the one I married
- ☐ Had not dated at all
- ☐ I've never been married

I have:

- ☐ Never been married
- ☐ Been married only once
- ☐ Been married two times
- ☐ Been married three times or more

I am now (check all that apply):

- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed
- ☐ Living with partner but not married
- ☐ Living with a homosexual partner
- ☐ Living alone
- ☐ Living with family
- ☐ Living with friends
- ☐ Other (explain)

My relationship with my current spouse or sexual partner is:

- ☐ Excellent
- ☐ Good
- ☐ Poor
- ☐ Very Poor

I now have:

- ☐ No close friends
- ☐ Only one close friend (same sex)
- ☐ Only one close friend (opp. sex)
- ☐ Several close friends (same sex)
- ☐ Several close friends (opp. sex)
- ☐ Several close friends (both sexes)

I belong to:

- ☐ No church, club or other social groups
- ☐ One group (specify) _____
- ☐ Several groups (specify) _____

I get together with friends or others socially:

- ☐ Never
- ☐ Seldom
- ☐ Fairly often (at least once per week)
- ☐ Very often (more than once per week)

In the past year I have engaged in the following activities:

☐ Reading	☐ Watching sports events	☐ Shooting pool
☐ Writing	☐ Swimming	☐ Drinking
☐ Listening to music	☐ Fishing	☐ Playing cards
☐ Watching TV	☐ Dancing	☐ Gambling
☐ Painting	☐ Bowling	☐ Working on cars
☐ Playing musical instruments	☐ Jogging	☐ Playing Video Games
☐ Movies	☐ Gardening	☐ "Surfing" internet

Other leisure activities I enjoy are:

_____

_____

_____

MENTAL HEALTH DATA

Describe the reasons for referral. Please include specific behaviors or problems that you would like help with.

_____

_____

_____

_____

How long has this been a problem? _____

What services or interventions have been previously performed (if any)?

_____

_____

_____

Have you received counseling services in the past (outpatient or outpatient)? ☐ No ☐ Yes

If "yes", please explain (include dates):

_____

_____

_____

_____

Are you currently taking or have you ever been prescribed any medication for psychological or psychiatric reasons?

☐ Yes ☐ No

Name	Dosage	Reason	Prescribed by

Please indicate any family members on either side who have had any of the following.

Psychiatric Problems	Mother's Side	Father's Side
Depression / Suicide		
Bipolar (Manic-Depression)		
Anxiety Disorder		
Panic Attacks		
Obsessive-Compulsive Disorder		
Phobias and Fears		
Autism Spectrum Disorder		
Schizophrenia		
Hallucinations		
Alcohol / Drug Abuse (specify)		
"Nervous Breakdowns"		
Other		

ADDITIONAL INFORMATION

Please provide any other information or describe any other concerns which have not been covered in this questionnaire.