SWOSU
TM
Southwestern Oklahoma State University

Student ID___________________________ **Date**_____________________________________

Personal Information

First Name _____________________________________ MI _____ Last Name ______________________________________

Age _________ Date of Birth _________________ Referred by ____

Sexual Orientation:____ Ethnicity ____

Insurance Provider: ____

Contact Information

Local Address		
City	State	Zip
Phone Number	Cell Phone Number	
Email Address		
Hometown/Country		
Last Visit to PCP- (Primary Care Physician)		
Are you registered with the office for disability services, as having a documented and diagnosed disability? If so, please include.		

Emergency Contact Information

First Name	MI	Last Name
Phone Number		
City	State	Zip
Relationship to client		

Academic/Career Information

Freshman	Sophomore	Junior	Senior	Graduate

Major/Minor	GPA	Advisor
Future		
Current Job or Career		

What brings you to our office?

____

____

____

When did you first notice the problem?

____

How likely do you think it is that the problem can be resolved? (circle one)

1	**2**	**3**	**4**	**5**
Very unlikely	Somewhat unlikely	Unsure	Somewhat likely	Very likely

How will you know when the problem is resolved? What will be different?

____

____

Briefly describe your goals for treatment:

____

____

Behavioral

Do you exercise? If so, how often?

____

Have there been any recent changes in your eating habits?

____

Have there been any recent changes in your sleeping habits?

____

What do you do for fun?

____

Do you have habits that may be viewed as unhealthy? (Ex. gambling, pornography, binge drinking)

____

Relationships

Who are the people in your life that you can rely on during difficult times?

____

Are you in a relationship? If so, are you currently happy with it?

____

How are your family relationships?

____

Do you have children? If so, how many?

____

Are you currently experiencing any abuse in your relationships? (Physical, emotional, sexual)

____

Spirituality

What are your spiritual beliefs?

____

Substance Use

How much caffeine do you consume per day? ____

Please list any substances you use regularly (e.g., tobacco products, alcohol, marijuana, other drugs):

____

____

Have you ever felt concerned about your drug or alcohol intake?

____

Do you have any family members who have struggled with addiction?

____

Affect/Mood
Circle any of the following that describe how you feel on a regular basis.

Excited	Hyper	Restless	Optimistic	Cheerful	Content	Hopeful	Calm
Depressed	Alone	Hurt	Hopeless	Lost	Distressed	Unhappy	Moody
Furious	Enraged	Betrayed	Upset	Mad	Annoyed	Irritable	Defensive
Panicky	Frantic	Scared	Apprehensive	Threatened	Insecure	Intimidated	Nervous
Worthless	Sorrowful	Guilty	Ashamed	Unworthy	Secretive	Embarrassed	Regretful

Do you engage in self-harming behaviors (cutting, scratching, hitting, burning, purging)?

____

Do you have thoughts of death, suicide, or plans to attempt suicide? If yes, please describe.

____

____

____

Have you attempted suicide in the past? When?

____

____

Has anyone in your family ever attempted suicide or died by suicide? Yes_______ No________
_

Have you ever received treatment for mental health (inpatient or outpatient)? If so, please list reason(s):

____

____

Current Medications:

____

____

Current or Previous Mental Health Diagnosis:

____

____

In the PAST TWO WEEKS, I have had problems with:

- ☐ Lower Academic Performance
- ☐ Poor Class Attendance
- ☐ Relationship conflict (family, friend, roommate, partner)
- ☐ Social Avoidance/Withdrawal
- ☐ Sleep Disturbance
- ☐ Eating/Weight/Body Image
- ☐ Anxiety
- ☐ Social Anxiety
- ☐ Perfectionism
- ☐ Phobias/Extreme Fears
- ☐ Obsessive Thinking
- ☐ Compulsive Behaviors (checking, counting, cleaning)
- ☐ Agitation/Restlessness
- ☐ Increased Activity Level/Over Exercising
- ☐ Athletics/Sports Performance
- ☐ Depression
- ☐ Decreased Interest/Pleasure

In the COURSE OF MY LIFE, I have had problems with:

- ☐ Adjustment/Transition to College
- ☐ Lower Academic Performance
- ☐ Poor Class Attendance
- ☐ Relationship Conflict (family, friend, partner)
- ☐ Social Avoidance/Withdrawal
- ☐ Sleep Disturbance
- ☐ Eating/Weight/Body Image3
- ☐ Anxiety
- ☐ Perfectionism
- ☐ Phobias/Extreme Fears
- ☐ Obsessive Thinking
- ☐ Compulsive Behaviors (checking, counting, cleaning)
- ☐ Agitation/Restlessness
- ☐ Increased Activity Level/Over Exercise
- ☐ Athletics/Sports Performance
- ☐ Depression
- ☐ Decreased Interest/Pleasure

☐ Fatigue/Low Energy	☐ Fatigue/Low Energy
☐ Illness/Physical Medical Health	☐ Illness/Physical/Medical Health
☐ Traumatic Experience e	☐ Traumatic Experience
☐ PTSD/Flashbacks/Nightmares	☐ PTSD/Flashbacks/Nightmares
☐ Greif/Loss	☐ Greif/Loss
☐ Auditory/Visual Hallucinations	☐ Auditory/Visual Hallucinations
☐ Alcohol Abuse	☐ Alcohol Abuse
☐ Marijuana Abuse	☐ Marijuana Abuse
☐ Prescription Medication Abuse	☐ Prescription Medication Abuse
☐ Stimulant Abuse	☐ Stimulant Abuse
☐ Opiate Abuse	☐ Opiate Abuse
☐ Sedative/Hypnotic/Hallucinogen Abuse	☐ Sedative/Hypnotic/Hallucinogen Abuse
☐ Other Drug Abuse	☐ Other Drug Abuse
☐ Other Addictive Behaviors (gambling, porn, internet)	☐ Other Addictive Behavior (gambling, porn, internet)
☐ Self-Injurious Behavior	☐ Self-Injurious Behavior
☐ Suicidal Thoughts	☐ Suicidal Thoughts
☐ Homicidal Thoughts/Violence	☐ Homicidal Thoughts/Violence
☐ University Disciplinary/Conduct Issues	☐ University Disciplinary/Conduct Issues
☐ Legal/Arrest/Police Involvement	☐ Legal/Arrest/Police Involvement
☐ Referral by Attorney/Court	☐ Referral by Attorney/Court
☐ Smoker	☐ Smoker
☐ Traumatic Event-Emotional	☐ Traumatic Event-Emotional
☐ Traumatic Event-Physical	☐ Traumatic Event-Physical
☐ Traumatic Event-Sexual	☐ Traumatic Event-Sexual
☐ Traumatic Event ________________	☐ Traumatic Event ____________________
☐ Hallucinations	☐ Hallucinations

☐ Financial Stress Now ☐ Yes ☐ No

☐ Prior Counseling ☐ Yes ☐ No

☐ Family Mental Health History: ☐ Yes ☐ No Please describe: ______________________

☐ Prior Meds:

☐ Prior Hospitalizations:

☐ Self-Injury (How Many)

☐ Suicide Attempt (How Many)

☐ Considered Harming (How Many)

☐ Harmed Another (How Many)

☐ Harassment/Abuse (How Many)

☐ PTSD Experience (How Many)

Please select any traumatic events(s) you have experienced:

☐ Childhood abuse (physical, emotional, sexual)

☐ Physical attack

☐ Sexual violence

☐ Military combat or war zone experiences

☐ Kidnapped or taken hostage

☐ Serious accident, fire, or explosion

☐ Near drowning

☐ Diagnosed with life threatening illness

☐ Natural disaster

☐ Imprisonment or torture

Please return this packet to the reception desk. Someone will be with you shortly.

THERAPIST NOTES REGARDING PRESENTING PROBLEM (AS NEEDED)
RECOMMENDATIONS FOR TREATMENT

☐ **Referral to Campus Supports**

Check all that apply:
- ☐ Academic supports/Student Success Center
- ☐ Career Services
- ☐ Group Fitness
- ☐ Health Services
- ☐ Residence Life
- ☐ Student Success Center
- ☐ Other ______________________________

☐ **Referral to Peer Supports**
- ☐ Active Minds
- ☐ Academic Coaches
- ☐ **Student Organizations**

☐ **Self-help Psychoeducation**
- ☐ Access to TAO modules
- ☐ Apps and websites
- ☐ Flourishing Courses
- ☐ TAO Self-help Modules
- ☐ Wellness Room
- ☐ Workshops

☐ **Problem-Focused Session**
- ☐ Single Session-One problem one solution

☐ **Group Therapy**
- ☐ Another Chapter in Life/Freshmen
- ☐ Anxiety/Depression
- ☐ Dating/Relationships
- ☐ Eight Dimensions of Wellness
- ☐ Journaling
- ☐ Self-love/Self-esteem

☐ **TAO-Therapy Assistance Online**
- ☐ Video Conference

☐ **Individual Therapy**
- ☐ BetterHelp Online Counseling Services
- ☐ SWOSU Counseling Services

☐ **Off-Campus Referral**
- ☐ Crisis Management
- ☐ Court Ordered
- ☐ Intensive or long-term treatment
- ☐ Psychological Testing

☐ **No additional services scheduled at this time.**

☐ **Client willing/able to follow recommendations.** ☐ Yes ☐ No

☐ **Client response to recommendations (if applicable)**