

Date \_\_\_\_\_

STUDENT COUNSELING CENTER

CLIENT DATA SHEET

The following forms will take a few minutes to complete and will provide information which will help your therapist better understand your concerns.

CONFIDENTIALITY

*This information is CONFIDENTIAL. Ordinarily, no client information will be released to ANY source unless the client gives written permission. However, if an urgent situation occurs in which permission is not obtainable, your therapist reserves the right to discuss pertinent information with other professionals such as psychologists and physicians who would be involved in helping you. If you would like further information or have any questions about the Center's policy on Confidentiality, your therapist will be happy to discuss it with you.*

Name \_\_\_\_\_

Local Phone (            ) \_\_\_\_\_

Local Address (street, city, state, zip)

\_\_\_\_\_

Campus mailbox or zip \_\_\_\_\_  
email \_\_\_\_\_

College/Program \_\_\_\_\_

Yr. in program \_\_\_\_\_

Previous college education (List college(s) and degrees/certificates earned)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Hometown \_\_\_\_\_

High School \_\_\_\_\_

Military service (branch, dates of service)

\_\_\_\_\_

Currently employed? No \_\_\_\_\_ Yes \_\_\_\_\_

Where employed? \_\_\_\_\_

Sex \_\_\_\_\_ Age \_\_\_\_\_ Marital Status: single \_\_\_\_\_ married \_\_\_\_\_  
divorced \_\_\_\_\_ separated \_\_\_\_\_

Date of marriage: \_\_\_\_\_ widowed \_\_\_\_\_ unmarried, living w/partner \_\_\_\_\_

Name of spouse/significant other: \_\_\_\_\_

Occupation: \_\_\_\_\_

List children (name, age, gender):

\_\_\_\_\_

Name(s) of roommate(s):

\_\_\_\_\_

Parents: Name \_\_\_\_\_ Age \_\_\_\_\_  
Occupation \_\_\_\_\_

Father \_\_\_\_\_

\_\_\_\_\_

Mother \_\_\_\_\_

\_\_\_\_\_

Parent's marital status: Living together \_\_\_\_\_ Divorced/separated \_\_\_\_\_

Father deceased \_\_\_\_\_ Mother deceased \_\_\_\_\_ Both deceased \_\_\_\_\_

Brothers/Sisters (name, age, occupation)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

EMERGENCY CONTACT:

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

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

Address: \_\_\_\_\_

Relationship to you: \_\_\_\_\_

## II. COUNSELING HISTORY

- A. Please list any previous professional counseling you have had, starting with the most recent:

Name of Therapist/Agency, City  
Reason

Dates fr- to

_____	_____
_____	
_____	_____
_____	
_____	_____
_____	

- B. Please list any previous psychiatric medical treatment you have had, starting with the most recent:

OUTPATIENT

Name of Doctor/Agency  
Reason

Dates fr-to

_____	_____
_____	
_____	_____
_____	
_____	_____
_____	

INPATIENT HOSPITALIZATION

_____	_____
_____	

MEDICATIONS PRESCRIBED (anti-depressant, anti-anxiety, etc.)

\_\_\_\_\_

- C. Have you been treated for alcohol/substance abuse? (When, where?)

\_\_\_\_\_

III. MEDICAL HISTORY

- A. Describe any recent or current medical problems. How long?

\_\_\_\_\_



6. Inability to concentrate	1	2	3	4	5
7. Academic concerns (grades, test anxiety, etc.)	1	2	3	4	5
8. Troubling thoughts or dreams	1	2	3	4	5
9. Self-critical thinking.	1	2	3	4	5
10. Chronic muscle tension	1	2	3	4	5
11. Suicidal thoughts	1	2	3	4	5
12. Headaches or visual disturbances	1	2	3	4	5
13. Loss of appetite	1	2	3	4	5
14. Upset stomach/GI tract	1	2	3	4	5
15. Compulsive eating	1	2	3	4	5
16. Excessive alcohol or drug use	1	2	3	4	5
17. Dizziness or racing heart	1	2	3	4	5
18. Unreasonable fears	1	2	3	4	5
19. Irritable or angry feelings	1	2	3	4	5
20. Inability to sleep well	1	2	3	4	5
21. Problems with friends	1	2	3	4	5
22. Family problems	1	2	3	4	5
23. Work-related problems	1	2	3	4	5
24. Couples communication problems	1	2	3	4	5
25. Sexual problems	1	2	3	4	5

## Burns Depression Checklist \* (Revised)

Instructions: Put a check (✓) to indicate how much you have experienced each symptom during the past week, including today. Please answer all 25 items.

<b>0--Not At All</b>	<b>1--Somewhat</b>	<b>2--Moderately</b>	<b>3--A Lot</b>	<b>4--Extremely</b>
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Thoughts and Feelings				
1. Feeling sad or down in the dumps				
2. Feeling unhappy or blue				
3. Crying spells or tearfulness				
4. Feeling discouraged				
5. Feeling hopeless				
6. Low self-esteem				
7. Feeling worthless or inadequate				
8. Guilt or shame				
9. Criticizing yourself or blaming yourself				
10. Difficulty making decisions				
Activities and Personal Relationships				
11. Loss of interest in family, friends or colleagues				
12. Loneliness				
13. Spending less time with family or friends				
14. Loss of motivation				
15. Loss of interest in work or other activities				
16. Avoiding work or other activities				
17. Loss of pleasure or satisfaction in life				
Physical Symptoms				
18. Feeling tired				
19. Difficulty sleeping or sleeping too much				
20. Decreased or increased appetite				
21. Loss of interest in sex				
22. Worrying about your health				
Suicidal Urges **				
23. Do you have any suicidal thoughts?				
24. Would you like to end your life?				
25. Do you have a plan for harming yourself?				

Please Total Your Score on Items 1 to 25 Here →

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\* Copyright © 1984 by David D. Burns, M.D. (Revised, 1996.)

\*\* Anyone with suicidal urges should seek help from a mental health professional.

## Burns Anxiety Inventory \* (Revised)

Instructions: Put a check (✓) to indicate how much you have experienced each symptom during the past week, including today. Please answer all 25 items.

	0--Not At All	1--Somewhat	2--Moderately	3--A Lot	4--Extremely
<b>Anxious Thoughts and Feelings</b>					
1. Feeling anxious					
2. Feeling nervous					
3. Feeling frightened					
4. Feeling scared					
5. Worrying about things					
6. Feeling that you can't stop worrying					
7. Feeling tense, agitated or on edge					
8. Feeling stressed					
9. Feeling "uptight"					
10. Thoughts that something frightening will happen					
11. Feeling alarmed or in danger					
12. Feeling insecure					
<b>Anxious Physical Symptoms</b>					
13. Feeling dizzy, lightheaded or off balance					
14. Rubbery or "jelly" legs					
15. Feeling like you are choking					
16. A lump in the throat					
17. Feeling short of breath or difficulty breathing					
18. Skipping, racing or pounding of the heart					
19. Pain or tightness in the chest					
20. Restlessness or jumpiness					
21. Tight, tense muscles					
22. Trembling or shaking					
23. Numbness or tingling					
24. Butterflies or discomfort in the stomach					
25. Sweating or hot flashes					
<b>Please Total Your Score on Items 1 to 25 Here →</b>					