APPENDIX D
Cumberland University Counseling Center
Client Questionnaire

NAME _____ DATE _____

SOCIAL SECURITY #: _____-_____-_____ AGE _____ DOB _____/_____/_____

LOCAL ADDRESS _____ CU Box #_____
Street or Residence Hall City Zip

LOCAL OR CELL PHONE #: (_____)_____-_____ MAY WE LEAVE MESSAGES? Yes ___ No___

PERMANENT OR FAMILY ADDRESS: PERMANENT OR FAMILY PHONE #: (____)_____-_____

_____
Street City State Zip

GENDER: M____ F ____ DATE OF ENTRY TO CU _____ MAJOR _____GPA _____

MARITAL STATUS	UNIVERSITY STATUS	LIVING SITUATION	RACE/ETHNICITY
___Never Married	___ Freshman	___Alone	___Caucasian
___Married	___ Sophomore	___Roommate(s)	___African American
___Divorced	___Junior	___Spouse	___Hispanic
___Widowed	___Senior	___Partner	___Asian or Pacific Islander
___Separated	___Graduate	___Parents and/or Family	___Native American
___Living with Partner		___Other (specify)_____	___International Student *Country*_____
			___Other (specify)_____

ARE YOU A CURRENTLY ENROLLED STUDENT? Yes No

HOW MANY CREDIT HOURS ARE YOU TAKING THIS SEMESTER? _____

DO YOU WORK? _____ IF SO, HOURS PER WEEK? _____ WHERE? _____

PLEASE STATE BRIEFLY YOUR REASONS FOR COMING TO COUNSELING SERVICES AT THIS TIME.

WERE YOU REFERRED HERE? _____ IF SO, BY WHOM? _____

PLEASE ESTIMATE THE SEVERITY OF YOUR CONCERNS AT THIS TIME (CIRCLE ONE):

MILD MODERATE MARKED EXTREME CRISIS

RELIGIOUS PREFERENCE _____ LEISURE ACTIVITIES _____

DESCRIBE ANY CURRENT PHYSICAL PROBLEMS:

_____

_____

DESCRIBE ANY MAJOR PAST PHYSICAL PROBLEMS:

_____

_____

PLEASE LIST ANY MEDICATIONS AND/OR HERBAL TREATMENTS YOU CURRENTLY ARE TAKING:

_____

PLEASE LIST MEMBERS OF YOUR FAMILY:

Name	Relationship	Age	Education	Occupation
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

RELATIONSHIP OF PARENTS:

Never Married ____ Married ____ Separated_____ Divorced_____ Remarried? M____ F_____ Deceased? M_____ F_____

PLEASE LIST FAMILY MEMBERS WHOM YOU BELIEVE HAD OR HAVE A MENTAL HEALTH PROBLEM OR ALCOHOL/DRUG ABUSE (ex: mother – depression):

Relationship to You:		Problem:
_____	-	_____
_____	-	_____
_____	-	_____
_____	-	_____
_____	-	_____

HAVE YOU EVER EXPERIENCED DIFFICULTY WITH AN EATING DISORDER? Yes No Unsure

HAVE YOU EVER HAD AN UNWANTED SEXUAL EXPERIENCE? Yes No Unsure

HAVE YOU EVER BEEN PHYSICALLY ABUSED? Yes No Unsure

HAVE YOU EVER BEEN EMOTIONALLY ABUSED? Yes No Unsure

HOW OFTEN DO YOU DRINK ALCOHOL?

Daily Several times/week Once/week Several times/month Rarely Never

HOW MANY DRINKS DO YOU TYPICALLY CONSUME IN ONE SITTING? _____

DO YOU USE ANY DRUGS? Currently Past Never

ARE YOU CONCERNED ABOUT THE LEVEL OF YOUR ALCOHOL OR DRUG USE? Yes No

HAVE YOU BEEN SEEN AT THE CU COUNSELING SERVICES OFFICE BEFORE? Yes No

IF SO, BY WHOM? _____WHEN? _____

HAVE YOU CONSULTED A MENTAL HEALTH PROFESSIONAL IN THE PAST? Yes No

IF YES, PLEASE GIVE NAME AND APPROXIMATE DATES AND PLACES OF TREATMENT:

_____

_____

_____

_____

HAVE YOU EVER HAD TO LEAVE SCHOOL FOR MORE THAN 1 OR 2 DAYS FOR MENTAL HEALTH REASONS? _____Yes_____ No IF SO, PLEASE DESCRIBE THE SITUATION_____

_____

_____

_____

_____

_____

_____

Are you coming to the Counseling Center for assistance with career counseling? ____Yes ___No
If yes, please complete the following:

What majors and/or careers have you considered?

_____

_____

_____

Have you ever had any career testing or counseling before? _____ Yes _____ No

If yes, when_____

BY VOLUNTARILY PROVIDING INFORMATION FOR AN INDIVIDUAL TO CONTACT IN A SITUATION DEEMED BY THE COUNSELING SERVICES STAFF TO BE OF A SERIOUS OR EMERGENCY NATURE, YOU ALLOW US TO MAKE SUCH CONTACT.

CRISIS / EMERGENCY CONTACT PERSON(S): _____

RELATIONSHIP TO YOU: _____

PHONE NUMBERS: _____

PLEASE NOTIFY YOUR COUNSELOR IMMEDIATELY IF/WHEN THERE ARE ANY CHANGES IN YOUR CRISIS CONTACT INFORMATION.

SELF-REPORT FORM

The following is a list of concerns many people have. Please indicate those that are current concerns by rating each item according to the following scale. Please put a check mark under the "Past" column, if the concern was a problem in the past.

1	not at all
2	a little
3	moderately
4	quite a bit
5	extremely

	Current	**Past**
1.	_____Career exploration and planning	_____
2.	_____Academic progress	_____
3.	_____Test anxiety	_____
4.	_____Study habits or time management	_____
5.	_____Assertiveness	_____
6.	_____Social skills	_____
7.	_____Out of touch with my feelings	_____
8.	_____Phobias	_____
9.	_____Confused about my beliefs/values	_____
10.	_____Self-identity	_____
11.	_____Feeling dependent on others	_____
12.	_____Breakup of intimate relationship	_____
13.	_____Dating/relationship with partner	_____
14.	_____Relationship with parents/family	_____
15.	_____Relationship with roommate(s)	_____
16.	_____Loneliness/feeling isolated	_____
17.	_____Dealing with anger	_____
18.	_____Alcohol or drugs	_____
19.	_____Excessive Internet use	_____
20.	_____Sleep problems	_____
21.	_____Eating/weight problems	_____
22.	_____Physical appearance/body image	_____
23.	_____Death of a friend or loved one	_____
24.	_____Depression	_____
25.	_____Anxiety	_____
26.	_____Feeling unworthy or inferior	_____
27.	_____Worrying too much	_____
28.	_____ Self-Injury	_____
29.	_____Thoughts of suicide	_____
30.	_____Thoughts of hurting others	_____
31.	_____Arrest or legal problems	_____
32.	_____Adjustment to the university	_____
33.	_____Stress	_____
34.	_____Pregnancy (yours or hers)	_____
35.	_____Physical abuse, sexual abuse, neglect	_____
36.	_____Sexuality/intimate relationships	_____
37.	_____Sexual orientation	_____
38.	_____Financial Difficulties	_____
39.	_____Other	_____

(Please, describe) _____