

**BAYLOR UNIVERSITY COUNSELING CENTER (BUCC)**  
**Client Information Form**

**DIRECTIONS:** Please complete the following form which will help the clinician to provide for you a comprehensive service. After completion of this form, please give it to the front desk, in order to be seen. (If you have filled out this form online, please bring it to the walk-in clinic and turn it into the front desk when you arrive).

**ALL INFORMATION IS CONFIDENTIAL!**

How did you learn about the Counseling Center? \_\_\_\_\_

Date: \_\_\_\_\_ ID#: \_\_\_\_\_ Referral \_\_\_\_\_

**Phone Where You Can Be Reached** \_\_\_\_\_

Can we call you at your phone number? Yes or No (please circle one)

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

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Race/Ethnicity \_\_\_\_\_

International Student? Y\_\_ N\_\_ Any Disabilities? Y\_\_ N\_\_ If YES describe \_\_\_\_\_

Gender \_\_\_\_\_

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

City

State

Zip

E-mail Address: \_\_\_\_\_ (May we e-mail you?) Y\_\_ N\_\_

(Note: Because e-mail is not confidential, we strongly discourage you from using e-mail to communicate sensitive information with your counselor.)

**Reason For Counseling:** Explain primary reasons why you are seeking counseling:

**If Crisis:** Are you having thoughts of suicide or doing serious harm to yourself? Y\_\_ N\_\_

Do you have a plan? Y\_\_ N\_\_ Intend to act on this plan in the near future? Y\_\_ N\_\_

Are you having thoughts of doing serious harm to someone else? Y\_\_ N\_\_

Do you have a plan? Y\_\_ N\_\_ Intend to act on this plan in the near future? Y\_\_ N\_\_

I have recently been physically or sexually assaulted or was victimized in a recent crime or accident. Y\_\_ N\_\_

I am hearing voices or seeing things that others do not hear or see. Y\_\_ N\_\_

**(Please fill out other side)**

Roommates(s): (1) \_\_\_\_\_ (2) \_\_\_\_\_  
 (3) \_\_\_\_\_ (4) \_\_\_\_\_  
 Employment: \_\_\_\_\_ Hrs. per week: \_\_\_\_\_

Do you have health insurance? Y\_\_N\_\_ If so, what company? \_\_\_\_\_  
 Policy Group # \_\_\_\_\_ Member/Subscriber # \_\_\_\_\_  
 NOTE: Baylor University Counseling Center DOES NOT file insurance for you. However, we can provide receipts for you to file with your insurance company.

***FAMILY INFORMATION:***

	NAME	AGE	LEVEL OF EDUCATION	OCCUPATION
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Siblings	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

Parent's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Parent's Phone Number: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (CP) \_\_\_\_\_  
 (H) \_\_\_\_\_ (W) \_\_\_\_\_ (CP) \_\_\_\_\_

***ACADEMIC INFORMATION:***

Classification: \_\_\_\_\_ Hours attempted this semester: \_\_\_\_\_ Overall  
 GPA: \_\_\_\_\_ Expected Date of Graduation: \_\_\_\_\_ Major: \_\_\_\_\_  
 Probable Occupation: \_\_\_\_\_

***GENERAL INFORMATION:***

Have you received services from the Baylor Counseling Center before? Y\_\_N\_\_ If yes, please check all that are applicable:

\_\_\_\_ Counseling: Dates: \_\_\_\_\_  
 \_\_\_\_ Psychiatric: Dates: \_\_\_\_\_  
 \_\_\_\_ Nutritional: Dates: \_\_\_\_\_

Have you previously received psychological/psychiatric services elsewhere? Y\_\_N\_\_

If yes, date(s) and type of service: \_\_\_\_\_

Have you ever been hospitalized for psychological/psychiatric care? Y\_\_ N\_\_

If yes, date(s) and reason: \_\_\_\_\_

Do you have any medical problems for which you are currently being treated? Y\_\_N\_\_

If yes, please explain: \_\_\_\_\_

Are you taking any medication(s)? Y\_\_N\_\_

If yes, please list: \_\_\_\_\_

Have you ever been arrested for or convicted of a crime? Y\_\_N\_\_

If yes, date(s) and reason for arrest(s) or conviction(s): \_\_\_\_\_

Please check the times when you are <u>AVAILABLE</u> for counseling.					
	Monday	Tuesday	Wednesday	Thursday	Friday
8 AM					
9 AM					
10 AM					
11 AM					
1 PM					
2 PM					
3 PM					
4 PM					

**(Please fill out other side)**

***Please check any of the following concerns you are currently experiencing or have experienced:***

<u>Present</u>	<u>Past</u>	
_____	_____	Anxiety
_____	_____	Depression
_____	_____	Thoughts of suicide
_____	_____	Suicide attempt(s)
_____	_____	Bipolar disorder
_____	_____	Unwanted sexual experience
_____	_____	Sleep disturbance
_____	_____	Changes in appetite
_____	_____	Academic problem
_____	_____	Relationship concerns (e.g. break up, conflict)
_____	_____	Relationship violence (e.g. emotional, physical, sexual, verbal abuse)
_____	_____	Panic attacks
_____	_____	Shyness or Social Anxiety
_____	_____	Test Anxiety
_____	_____	Obsessive compulsive behavior
_____	_____	Phobia
_____	_____	Stress
_____	_____	Self-Injury (e.g. cutting, burning, banging head, etc.)
_____	_____	Difficulty concentrating
_____	_____	ADHD
_____	_____	Low motivation or energy
_____	_____	Severe mood swings
_____	_____	Loneliness
_____	_____	Anorexia
_____	_____	Bulimia
_____	_____	Disordered eating (binge eating, dieting, etc.)
_____	_____	Anger management
_____	_____	Family concerns
_____	_____	Traumatic event
_____	_____	Physical abuse
_____	_____	Sexual abuse
_____	_____	Pornography use
_____	_____	Gambling
_____	_____	Recent death or loss
_____	_____	Legal/Judicial Affairs problem
_____	_____	Alcohol abuse
_____	_____	Marijuana use
_____	_____	Other drugs (e.g. methamphetamine, cocaine, etc.)
_____	_____	Sexual dysfunction
_____	_____	Health concern
_____	_____	Work-related concern
_____	_____	Identity problem
_____	_____	Religious or spiritual problem
_____	_____	Cultural concerns
_____	_____	Excessive video or online game use
_____	_____	Other: _____

**(Please fill out other side)**

**BUCC SERVICES:**

At Baylor University **Counseling Center Group Services are our recommended treatment.** Please check the groups below that you are interested in.

Creative Arts Group\_\_\_\_ Interpersonal Process Group \_\_\_\_ Social Confidence Group\_\_\_\_  
Adult Children of Alcoholics-ACOA\_\_\_\_ Addiction & Recovery Process Group\_\_\_\_  
Seeking Safety Group\_\_\_\_ Mindfulness Skills Based Group\_\_\_\_

We can also refer you to additional Groups Outside the center.

Alcoholics Anonymous (2)\_\_\_\_ My sister, My Self (Support Group for Women of Color)\_\_\_\_  
Grief Support Group \_\_\_\_

At Baylor University Counseling Center we also offer psycho-educational materials and consultation services. When appropriate, we offer short-term counseling based on availability of counselors. If your concerns are outside our short-term scope of service, or require a specialization we do not offer, we can provide an assisted referral process to help you find the right resource. **Please check the services you are interested in discussing with the triage counselor at your first appointment.**

____Self-help materials	____Group counseling
____Brief problem-solving (1-2 sessions)	____Referral to other appropriate services
____Short-Term Individual counseling, short (1-4 sessions)	____Psychiatric assessment and services
____Short-Term Individual counseling (4-12 sessions)	____Dietitian assessment and services
____Long-term individual counseling	____Addictive Behavior assessment and services

**How are your concerns affecting you ACADEMICALLY?** Check all that apply.

\_\_\_\_Concentration \_\_\_\_Academic Probation \_\_\_\_Performance \_\_\_\_Failing Exam(s) \_\_\_\_ Grades  
\_\_\_\_Missing assignment(s) \_\_\_\_Absenteeism \_\_\_\_Other \_\_\_\_\_  
\_\_\_\_None of the above

**FAMILY HISTORY:** (Check any that are/were present in your family.)

Who in your family has experienced:

____Depression	_____
____Anxiety	_____
____Substance Abuse	_____
____Suicide Attempt	_____
____Physical Abuse	_____
____Sexual Abuse	_____
____Eating Disorder	_____
____Other Psychiatric/Emotional Disturbance (explain)	_____
_____	_____
____None	

Who are the people you can turn to for support? \_\_\_\_\_

What do you do for self-care (i.e. hobbies, interests, etc.)? \_\_\_\_\_  
\_\_\_\_\_