The UNIVERSITY of OKLAHOMA
Health Sciences Center
Student Counseling Services

PERSONAL INFORMATION FORM

TODAY'S DATE: _____

NAME: FIRST _____ M _____ LAST _____

DATE OF BIRTH: _____ **OUHSC ID #:** _____

GENDER IDENTITY: □ Male □ Female □ Transgender □ Prefer not to answer □ Self-Identify: _____

DO YOU LIVE: □ On-Campus □ Off-Campus

STREET ADDRESS: _____ **APT #:** _____

CITY: _____ **STATE:** _____ **ZIP:** _____

MOBILE PHONE #: _____ **MAY WE LEAVE A MESSAGE?** □ Yes □ No

OTHER PHONE #: _____ **MAY WE LEAVE A MESSAGE?** □ Yes □ No

EMAIL ADDRESS: _____ **MAY WE SEND EMAIL MESSAGES?** □ Yes □ No

(Please note that email is not a secure medium and therefore, the confidentiality of communications made in this manner cannot be guaranteed.)

COLLEGE: □ Allied Health □ Dentistry □ Graduate □ Nursing □ Medicine □ Pharmacy □ Public Health
□ N/A (not a student – partner/spouse of student).

YEAR/CLASS: □ 1st □ 2nd □ 3rd □ 4th □ 5th □ Residency □ Staff/Faculty □ Other (please specify): _____

PLEASE SPECIFY PROGRAM OF STUDY (PHYSICIAN ASSOCIATE, DENTAL HYGIENE, PHYSICAL THERAPY, ETC.):

_____

SEXUAL ORIENTATION: □ Heterosexual □ Gay □ Lesbian □ Bisexual □ Questioning □ Self-Identify _____
□ Prefer not to answer

RELATIONSHIP STATUS: □ Single □ Serious Dating/Committed Relationship □ Married
□ Civil Union/Domestic Partnership/Equivalent □ Separated □ Divorced □Widowed

LIVING SITUATION (PLEASE CHECK ALL THAT APPLIES): □ Alone □ Spouse/Partner/Significant Other
□ Roommate(s) □ Child(ren) □ Parent(s)/Guardian(s) □ Family Other □ Other (please specify): _____

ETHNICITY/RACE (OPTIONAL): □ Arab American □ African American/Black □ Anglo American/White
□ Asian American/Pacific Islander □ East Indian American □ Hispanic American/Latino □ Native American
□ More than one ethnicity □ Prefer not to answer □ Other (please specify): _____

INTERNATIONAL STUDENT? □ Yes □ No **IF YES, PLEASE SPECIFY COUNTRY OF ORIGIN:** _____

RELIGIOUS/SPIRITUAL PREFERENCE : □ Agnostic □ Atheist □ Baha'ism □ Buddhism □ Christianity
□ Confucianism □ Hinduism □ Islam □ Jainism □Judaism □ Shintoism □ Sikhism
□ No Preference □ Prefer not to answer □ Self-Identify _____

OVER

DOCUMENTED DISABILITY (CHECK ALL THAT APPLY): □ None □ Difficulty Hearing □ Difficulty Seeing

□ Difficulty Speaking / Language Impairment □ Mobility Limitation / Orthopedic Impairment

□ Traumatic Brain Injury □ Specific Learning Disability □ Attention Deficit Hyperactivity Disorder

□ Autism Spectrum Disorders □ Cognitive Difficulties / Intellectual Disability

□ Health Impairment or Chronic Condition □ Psychological or Psychiatric Condition

□ Other (please specify): _____

WHO REFERRED YOU TO STUDENT COUNSELING SERVICES (SCS): □ Self □ Dean □ Professor/Advisor

□ Partner/Spouse □ Friend □ Physician □ Other Counselor □ Other (please specify): _____

HAVE YOU HEARD ABOUT STUDENT COUNSELING SERVICES FROM ANY OF THESE SOURCES? (PLEASE CHECK ALL THAT APPLY):

□ OUHSC webpage □ Friend/Relative □ Professor/Advisor □ Dean □ OUHSC staff member

□ Student Counseling Services (SCS) Presentation □ SCS Printed Materials (Pamphlets, etc.)

□ Other student who has utilized SCS □ Other (please specify): _____

EMERGENCY CONTACT NAME: _____

EMERGENCY CONTACT PHONE NUMBER: _____

ARE YOU CURRENTLY TAKING PRESCRIBED MEDICATION? □ Yes □ No **(IF YES, PLEASE LIST MEDICATIONS AND DIAGNOSES):**

_____ _____

_____ _____

_____ _____

_____ _____

ARE YOU CURRENTLY IN COUNSELING? □ Yes □ No **(IF YES, WHAT TYPE OF COUNSELING AND WITH WHOM)**:

_____

_____

PREVIOUS COUNSELING AT STUDENT COUNSELING SERVICES? □ Yes □ No

HAVE YOU ATTENDED COUNSELING ELSEWHERE IN THE PAST? □ Yes □ No

IF YES, PLEASE INDICATE WHEN AND WITH WHOM: _____

_____

FREQUENCY PER WEEK OF PHYSICAL ACTIVITY: □ None □ Occasional participation (monthly)

□ One regularly attended activity per week □ Two regularly attended activities per week

□ Three or more regularly attended activities per week.

TYPE OF PHYSICAL ACTIVITY(IES) : _____

EXTRA-CURRICULAR ACTIVITIES LEVEL (CLUBS, SOCIAL GROUPS, ETC.): □ None □ Occasional participation (monthly)

□ One regularly attended activity per week □ Two regularly attended activities per week

□ Three or more regularly attended activities per week.

TYPE OF SOCIAL ACTIVITY(IES) : _____

IN JUST A FEW WORDS, PLEASE BRIEFLY SUMMARIZE WHAT BRINGS YOU TO SEEK SERVICES TODAY : _____

_____

_____

PROBLEM CHECKLIST:

Please read over this list of possible concerns. Using the following scale, check the appropriate box of current concerns. If an item is not a concern for you, please leave it blank or mark 0.

	0 No problem	**Slight Problem 1**	**2**	**3**	**4**	**5 Highly Significant Problem**
1. Academic/school work/grades	□ 0	□ 1	□ 2	□ 3	□ 4	□ 5
2. Adjustment Issues	□ 0	□ 1	□ 2	□ 3	□ 4	□ 5
3. Alcohol/drugs	□ 0	□ 1	□ 2	□ 3	□ 4	□ 5
4. Anxiety	□ 0	□ 1	□ 2	□ 3	□ 4	□ 5
5. Assertiveness	□ 0	□ 1	□ 2	□ 3	□ 4	□ 5
6. Breakup/loss of relationship	□ 0	□ 1	□ 2	□ 3	□ 4	□ 5
7. Concentration	□ 0	□ 1	□ 2	□ 3	□ 4	□ 5
8. Confusion about beliefs/values	□ 0	□ 1	□ 2	□ 3	□ 4	□ 5
9. Dating concerns	□ 0	□ 1	□ 2	□ 3	□ 4	□ 5
10. Death/impending death of significant other	□ 0	□ 1	□ 2	□ 3	□ 4	□ 5
11. Decisions about career	□ 0	□ 1	□ 2	□ 3	□ 4	□ 5
12. Depression	□ 0	□ 1	□ 2	□ 3	□ 4	□ 5
13. Developing independence from family	□ 0	□ 1	□ 2	□ 3	□ 4	□ 5
14. Ethnic/racial discrimination	□ 0	□ 1	□ 2	□ 3	□ 4	□ 5
15. Eating problems (bingeing/vomiting/dieting, using laxatives, etc.)	□ 0	□ 1	□ 2	□ 3	□ 4	□ 5
16. Eating problems (fasting/avoiding food)	□ 0	□ 1	□ 2	□ 3	□ 4	□ 5
17. Finances	□ 0	□ 1	□ 2	□ 3	□ 4	□ 5
18. Homesickness	□ 0	□ 1	□ 2	□ 3	□ 4	□ 5
19. Irritability, anger, hostility	□ 0	□ 1	□ 2	□ 3	□ 4	□ 5
20. Making friends	□ 0	□ 1	□ 2	□ 3	□ 4	□ 5
21. Perfectionism	□ 0	□ 1	□ 2	□ 3	□ 4	□ 5
22. Physical health problems (e.g. headaches.)	□ 0	□ 1	□ 2	□ 3	□ 4	□ 5
23. Problem pregnancy	□ 0	□ 1	□ 2	□ 3	□ 4	□ 5
24. Procrastination/getting motivated	□ 0	□ 1	□ 2	□ 3	□ 4	□ 5
25. Rape/sexual assault/unwanted sex	□ 0	□ 1	□ 2	□ 3	□ 4	□ 5
26. Reading study skills problems	□ 0	□ 1	□ 2	□ 3	□ 4	□ 5
27. Relationship with family/parents/siblings	□ 0	□ 1	□ 2	□ 3	□ 4	□ 5
28. Relationship with friends/roommates/peers	□ 0	□ 1	□ 2	□ 3	□ 4	□ 5
29. Relationship with romantic partner/spouse	□ 0	□ 1	□ 2	□ 3	□ 4	□ 5
30. Religious/spiritual concerns	□ 0	□ 1	□ 2	□ 3	□ 4	□ 5
31. Self-esteem/self-confidence	□ 0	□ 1	□ 2	□ 3	□ 4	□ 5
32. Sexual concerns	□ 0	□ 1	□ 2	□ 3	□ 4	□ 5
33. Sexual identity/orientation issues	□ 0	□ 1	□ 2	□ 3	□ 4	□ 5
34. Sexual transmitted disease(s)	□ 0	□ 1	□ 2	□ 3	□ 4	□ 5
35. Shyness, being ill at ease with people	□ 0	□ 1	□ 2	□ 3	□ 4	□ 5
36. Sleeping problems	□ 0	□ 1	□ 2	□ 3	□ 4	□ 5
37. Stress management	□ 0	□ 1	□ 2	□ 3	□ 4	□ 5
38. Suicidal feelings/thoughts	□ 0	□ 1	□ 2	□ 3	□ 4	□ 5
39. Test/speech/performance anxiety	□ 0	□ 1	□ 2	□ 3	□ 4	□ 5
40. Time management	□ 0	□ 1	□ 2	□ 3	□ 4	□ 5
41. Uncertain about future/life after college	□ 0	□ 1	□ 2	□ 3	□ 4	□ 5
42. Weight problems/body image	□ 0	□ 1	□ 2	□ 3	□ 4	□ 5
43. Physical/Verbal/Emotional Abuse	□ 0	□ 1	□ 2	□ 3	□ 4	□ 5
44. Other (please specify): _____						