The UNIVERSITY of OKLAHOMA
Health Sciences Center
Student Counseling Services

PERSONAL INFORMATION FORM

TODAY'S DATE: _____

NAME: _____

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

SEX: □ □ Male □ □ Female □ □ Transgender □ □ Prefer not to answer

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.)

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

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

PLEASE SPECIFY PROGRAM OF STUDY (PHYSICIAN'S ASSISTANT, DENTAL HYGIENE, OCCUPATIONAL THERAPY, ETC.):

_____

YEAR/CLASS: □ □ 1st □□ 2nd □ □ 3rd □ □ 4th □ □ 5th □□ Other _____ Please specify □ N/A

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 □ □ Other (please specify): _____

WHAT IS YOUR SEXUAL ORIENTATION: □ □ Heterosexual □ □ Gay □ □ Lesbian □ □ Bisexual □
□ Questioning □ Prefer not to answer

OVER

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

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

DOCUMENTED DISABILITY (CHECK ALL THAT APPLY): □ □ None □ □ Attention Deficit Hyperactivity Disorder

□ □ Deaf or Hard of Hearing □ □ Learning Disorders □ □ Mobility Impairments □ □ Neurological Disorders

□ □ Physical/Health Related Disorders □ □ Psychological Disorder/Condition □ □ Visual Impairments

□ □ Other, Please specify: _____

HOW DID YOU HEAR ABOUT STUDENT COUNSELING SERVICES? (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: _____

EMERGENCY CONTACT NAME: _____

EMERGENCY CONTACT PHONE NUMBER: _____

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)_____

_____

ARE YOU CURRENTLY TAKING PRESCRIBED MEDICATION? □ □ YES □ □ NO

IF YES, PLEASE LIST MEDICATIONS AND DIAGNOSED CONDITION(S): _____

_____

_____

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) : _____

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) _____