

Georgetown University
Counseling and Psychiatric Service
CONFIDENTIAL STUDENT INFORMATION SHEET

Today's Date: _____

Your Name: _____ Social Security #: _____ - _____ - _____

Date of Birth: _____ Age: _____ Go Card #: _____

Status: __Full-time __Part-time # of credit hours this term: _____

What is your health insurance provider? __MEGA (Student Ins.) __Other: _____

Preferred Phone: (_____) _____ OK to leave message? __Yes __No

Alternate Phone: (_____) _____ OK to leave message? __Yes __No

Email Address: _____ OK to leave message? __Yes __No

Local Address: _____
Street /Dorm and Mailbox # _____ City _____ State _____ Zip _____

Permanent Address: _____
(if different) Street _____ City _____ State _____ Zip _____

Check if you are here to consult about a friend or another student, and leave the rest of this form blank.

ALL ANSWERS ARE OPTIONAL To enable us to serve you better, please complete the remainder of this form with as much information as you feel comfortable providing at this time.

Gender: __Male __Female Marital Status: _____

Race/Ethnicity: _____ Religious Identity: _____

School: _____ Major: _____ Year: 1st 2nd 3rd 4th Other: _____

Candidate for: __BA __MA __MD __PhD __JD __Other: _____ Cum. GPA: _____

Transfer student? __Yes __No If yes, from what school? _____ Date: _____

International Student? __Yes __No If yes, what country? _____ Perm. Resident? __Yes __No

Country of birth? _____ If not USA, when did you come to the USA? _____

Are you employed? __No __Part time __Full time Job(s): _____

Please list any medical conditions: _____ Allergies: _____

Previous counseling?: __Yes __No If yes, When: _____ With whom?: _____

Why? _____

Are you currently in treatment? __Yes __No If yes, with whom?: _____

Why? _____

Please list any current medication: _____

Past *psychiatric* medication: _____

Please list any previous hospitalization or ER visit for mental health reasons: When? _____

Why? _____

Please list any family history of mental health or substance abuse problems: _____

What kind of services are you seeking? 1-3 session problem solving Individual Counseling Medication
 Group counseling Couples counseling Alcohol/Drug Assessment Test anxiety
 Stress management Sports psychology Someone to listen Information Advice

How urgent are the concerns which bring you here? Not Urgent Urgent Very Urgent

Please describe, in your own words, the reason for your visit and your goals for counseling:

Please check all of the following items which are concerns at this time, and circle those which are most important.

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Abortion issues | <input type="checkbox"/> Drug use | <input type="checkbox"/> Legal problems | <input type="checkbox"/> Self-esteem issues |
| <input type="checkbox"/> Abuse – emotional, physical verbal, sexual, neglect | <input type="checkbox"/> Eating problems | <input type="checkbox"/> Loneliness, no friends | <input type="checkbox"/> Self-injury, mutilation |
| <input type="checkbox"/> Academic issues | <input type="checkbox"/> Emptiness | <input type="checkbox"/> Memory problems | <input type="checkbox"/> Self-neglect, poor self-care |
| <input type="checkbox"/> Advisor/faculty concern | <input type="checkbox"/> Family relationships | <input type="checkbox"/> Mood swings | <input type="checkbox"/> Sexual assault |
| <input type="checkbox"/> Aggression/violent behavior | <input type="checkbox"/> Fearing failure | <input type="checkbox"/> Motivation | <input type="checkbox"/> Sexual concerns |
| <input type="checkbox"/> Alcohol use | <input type="checkbox"/> Fears, phobias | <input type="checkbox"/> Overly responsible to others | <input type="checkbox"/> Sexual harassment |
| <input type="checkbox"/> Anger, arguing | <input type="checkbox"/> Financial problems | <input type="checkbox"/> Overly sensitive to rejection | <input type="checkbox"/> Sexual orientation/identity |
| <input type="checkbox"/> Anxiety, nervousness | <input type="checkbox"/> Gambling | <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Sexually transmitted disease |
| <input type="checkbox"/> Body image | <input type="checkbox"/> Grief issues | <input type="checkbox"/> Perfectionism | <input type="checkbox"/> Shame |
| <input type="checkbox"/> Career concerns, choices | <input type="checkbox"/> Guilt | <input type="checkbox"/> Peer relationship concerns | <input type="checkbox"/> Shyness, oversensitive |
| <input type="checkbox"/> Childhood issues (yours) | <input type="checkbox"/> Harassment | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Smoking, tobacco use |
| <input type="checkbox"/> Children/parenting concerns | <input type="checkbox"/> Health, medical concerns | <input type="checkbox"/> Prejudice/bias concerns | <input type="checkbox"/> Sleep problems |
| <input type="checkbox"/> Compulsive behaviors | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Procrastination/time mngt. | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Computer excessiveness | <input type="checkbox"/> Identity issues | <input type="checkbox"/> Racial/ethnic concerns | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> Concentration | <input type="checkbox"/> Impulsive, out of control | <input type="checkbox"/> Repeated troubling thoughts | <input type="checkbox"/> Tiredness, fatigue |
| <input type="checkbox"/> Decision making, indecision | <input type="checkbox"/> Independence from parents | <input type="checkbox"/> Relationship concerns | <input type="checkbox"/> Trauma |
| <input type="checkbox"/> Depression, sadness, crying | <input type="checkbox"/> International student concern | <input type="checkbox"/> Relationship violence | <input type="checkbox"/> Violent thoughts |
| <input type="checkbox"/> Divorce, separation | <input type="checkbox"/> Irresponsibility | <input type="checkbox"/> Religious/spiritual concerns | <input type="checkbox"/> Withdrawal, isolating |
| | <input type="checkbox"/> Learning disability | <input type="checkbox"/> Romantic relationship | <input type="checkbox"/> Other: _____ |

In the event of an **emergency** it may be necessary to contact a close family member or other responsible person. Please indicate the person(s) you would prefer to be contacted:

Name: _____ Relationship: _____

Phone (home): (_____) _____ Phone (work): (_____) _____

Address: _____
Street City State Zip

AVAILABLE HOURS Please circle all available hours you have this semester so that follow-up and ongoing meetings can easily be determined.

Monday	8	9	10	11	12	1	2	3	4	5	6
Tuesday	8	9	10	11	12	1	2	3	4	5	6
Wednesday	8	9	10	11	12	1	2	3	4	5	6
Thursday	8	9	10	11	12	1	2	3	4	5	6
Friday	8	9	10	11	12	1	2	3	4	5	6