

## Hamline University Counseling & Health Services Personal Data Form

<b>Last Name:</b>	<b>First Name:</b>	<b>MI:</b>	<b>Today's Date:</b>
<b>Hamline Mail #:</b>	<b>Date of Birth:</b>	<b>Age:</b>	<b>Hamline Phone #:</b>
<b>Permanent Address:</b>			<b>Cell Phone #:</b>
<b>E-mail Address:</b>			<b>Student ID #:</b>
<p>Have you received counseling in the past? Y __ N __ If yes, at Hamline <input type="checkbox"/> or off-campus <input type="checkbox"/>  Name of off-campus agency _____</p> <p>Have you received health services at this agency in the past? Y __ N __</p> <p>May we contact you by e-mail? Y __ N __</p> <p>May we write to you at your Hamline mailing address? Y __ N __ At your permanent address? Y __ N __</p> <p>May we contact you at your Hamline phone number? Y __ N __ OK to leave voice message? Y __ N __</p> <p>May we contact you at your cell phone number? Y __ N __ OK to leave voice message? Y __ N __</p>			
<b>University Status:</b> <input type="checkbox"/> First Year <input type="checkbox"/> Sophomore <input type="checkbox"/> Junior <input type="checkbox"/> Senior <input type="checkbox"/> Transfer student <input type="checkbox"/> Graduate Student, 1 <sup>st</sup> <input type="checkbox"/> 2 <sup>nd</sup> <input type="checkbox"/> 3 <sup>rd</sup> <input type="checkbox"/> year <input type="checkbox"/> Law Student, 1 <sup>st</sup> <input type="checkbox"/> 2 <sup>nd</sup> <input type="checkbox"/> 3 <sup>rd</sup> <input type="checkbox"/> year <input type="checkbox"/> Other _____  Major Program: _____ Are you an international student? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, from (country): _____		<b>Living with:</b> <input type="checkbox"/> Alone <input type="checkbox"/> Children <input type="checkbox"/> Partner <input type="checkbox"/> Spouse <input type="checkbox"/> Parents <input type="checkbox"/> Roommate(s) <input type="checkbox"/> Other <input type="checkbox"/> On campus <input type="checkbox"/> Off campus  <b>Enrollment:</b> <input type="checkbox"/> Full-Time GPA _____ <input type="checkbox"/> Part-time <input type="checkbox"/> Not enrolled Are you on academic probation? Yes <input type="checkbox"/> No <input type="checkbox"/>	
<b>Relationship Status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Partnered, not married <input type="checkbox"/> Other		<b>How many hours per week do you work?</b> <input type="checkbox"/> 0 <input type="checkbox"/> <10 <input type="checkbox"/> 10-20 <input type="checkbox"/> 20-30 <input type="checkbox"/> 30+	
<b>Race/Ethnicity (check all that apply):</b> <input type="checkbox"/> African American/Black <input type="checkbox"/> Asian/Asian-American/Pacific Islander <input type="checkbox"/> Caucasian/White <input type="checkbox"/> Hispanic/Latino(a) <input type="checkbox"/> Native American <input type="checkbox"/> Other		<b>Sexual Orientation:</b> <input type="checkbox"/> Gay <input type="checkbox"/> Lesbian <input type="checkbox"/> Heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Questioning <input type="checkbox"/> Don't know	
<b>Religious Affiliation/Spiritual Identity (optional):</b> Background: _____ Current: _____		<b>Gender:</b> <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender - MtF <input type="checkbox"/> FtM <input type="checkbox"/>	
<b>Referred by:</b> <input type="checkbox"/> Academic Services <input type="checkbox"/> Faculty <input type="checkbox"/> Physician      Was this a required referral? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Career Development Center <input type="checkbox"/> Family <input type="checkbox"/> RA or CA <input type="checkbox"/> Clergy <input type="checkbox"/> Friend <input type="checkbox"/> Residential Life <input type="checkbox"/> Counselor <input type="checkbox"/> Health Services <input type="checkbox"/> Roommate <input type="checkbox"/> Dean of Students <input type="checkbox"/> MISA Office <input type="checkbox"/> Self <input type="checkbox"/> Disability Services <input type="checkbox"/> Other <input type="checkbox"/> Therapist			

**Please check all of the reasons that you have come in:**

- |  |   |
|--|---|
| <input type="checkbox"/> ADD/ADHD                    | <input type="checkbox"/> Physical abuse             |
| <input type="checkbox"/> Academic/faculty concerns   | <input type="checkbox"/> Relationship problems      |
| <input type="checkbox"/> Adjustment/transition       | <input type="checkbox"/> Roommate problems          |
| <input type="checkbox"/> Alcohol/drug use            | <input type="checkbox"/> Self-esteem                |
| <input type="checkbox"/> Anxiety/stress              | <input type="checkbox"/> Sexual assault/harassment  |
| <input type="checkbox"/> Childhood sexual abuse      | <input type="checkbox"/> Sexuality                  |
| <input type="checkbox"/> Concern about someone else  | <input type="checkbox"/> Significant other          |
| <input type="checkbox"/> Depression/low mood         | <input type="checkbox"/> Sleep problems             |
| <input type="checkbox"/> Eating disorders/body image | <input type="checkbox"/> Social life/making friends |
| <input type="checkbox"/> Family                      | <input type="checkbox"/> Thoughts of harming self   |
| <input type="checkbox"/> Grief/Loss                  | <input type="checkbox"/> Thoughts of harming others |
| <input type="checkbox"/> Identity development        | <input type="checkbox"/> Other concerns: _____      |

**Please list below the people in your family and any other significant individuals in your life:**

Name	Relationship to you	Age	Occupation

**Please answer the following questions:**

- Have you ever been in trouble legally? [ ] Yes [ ] No
- Do you use alcohol and/or drugs? [ ] Yes [ ] No
- Is there a history chemical dependency in your family? [ ] Yes [ ] No [ ] Uncertain
- Is there a history of mental illness in your family? [ ] Yes [ ] No [ ] Uncertain
- Have you ever been physically abused? [ ] Yes [ ] No [ ] Uncertain
- Have you ever been sexually abused? [ ] Yes [ ] No [ ] Uncertain
- Have you ever been emotionally abused? [ ] Yes [ ] No [ ] Uncertain
- Have you been diagnosed with a disability? [ ] Yes [ ] No List: \_\_\_\_\_
- Do you have any current medical problems? [ ] Yes [ ] No List: \_\_\_\_\_
- Have you ever been hospitalized for psychiatric reasons? [ ] Yes [ ] No Date: \_\_\_\_\_
- Are you currently taking any prescription medications? [ ] Yes [ ] No List: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Is there anything else you would like us to know?** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_