Lesley University Counseling Center
New Client Information Form

All information will be kept strictly confidential

If for any reason you would prefer to fill this out with the help of your counselor, please just let us know.

First Name: **Middle:** **Last:**

Date of Birth:______/______/__________ **Current Age:** ____________ **Today's Date:**

Local Address:

____

(street) (city) (state) (zip code)

Permanent Address (if different):

____

(street) (city) (state) (zip code)

Phone #: ______________________________ **Email:** ____

Permission to Contact: Phone Yes / No E-mail Yes / No

Who referred you to the Counseling Center?

❑Self ❑Family ❑Online Screenings ❑Advisor ❑Dean of Students

❑Friends ❑Residence Life ❑Faculty ❑Health Services ❑Other

What do you hope to gain through meeting with a counselor? How will you know when things are better?

If you've been in counseling or therapy (individual or group) before:

Was it your choice? ☐ Yes ☐ No

Was it helpful? ☐ Yes ☐ No

What is your country of origin?

Relationship Status:

❑Single ❑Married ❑Separated ❑Divorced

❑Widowed ❑Serious dating or committed relationship

❑Civil union, domestic partnership or equivalent

►► ***Continue to next page*** ►►

Parents' Relationship:

- ☐ Never Married
- ☐ Married
- ☐ Civil Union/ Domestic Partnership
- ☐ Divorced
- ☐ Separated
- ☐ Widowed

If applicable, continue below:

Parent	Parent
☐ Single	☐ Single
☐ Remarried	☐ Remarried
☐ Committed Relationship	☐ Committed Relationship
☐ Civil Union/ Domestic Partnership	☐ Civil Union/ Domestic Partnership
☐ Unknown	☐ Unknown
☐ Deceased	☐ Deceased

Were you adopted?

☐ Yes ☐ No

Who raised you?

____

Anything else we should know?

____

____

What kind of housing do you currently have?

- ☐ On-campus residence hall
- ☐ Off-campus apartment/house
- ☐ Other (please specify): ___________________________

With whom do you live? (check all that apply)

- ☐ Alone ☐ Roommate(s)
- ☐ Children ☐ Parent or guardian(s)
- ☐ Spouse, partner, or significant other
- ☐ Other family
- ☐ Other (please specify): __________

Religious or Spiritual Preference:

Yours: ____________________

Parent: _________________

Parent: _________________

Primary Source of Income: (Check all that apply)

- ☐ Family
- ☐ Job
- ☐ Financial Aid
- ☐ Savings
- ☐ Other: _________________________________

GPA: _________________

Credits this semester: ______

Anticipated date of graduation: ________

☐ Full Time ☐ Part Time

Are you working with someone from Disability Services? Yes No Who? ____

Do you wonder if you may have a disability? Please Explain: ____

If yes to any of the above, which category of disability? (check all that apply):

- ☐ Attention Deficit/Hyperactivity
- ☐ Deaf or Hard of Hearing
- ☐ Learning Disorders
- ☐ Mobility Impairments
- ☐ Neurological Disorders
- ☐ Physical/health related Disorders
- ☐ Psychological Disorder/Condition
- ☐ Visual Impairments
- ☐ Other (please specify): _________

Please list any serious medical conditions or hospitalizations for medical reason that you have had:

Have you experienced head trauma or a concussion? Yes No

Continue to next page

Please provide the following information:

	Name	Age	Occupation	Education	Deceased? (Y/N)
Parent					
Parent					
Stepparent					
Stepparent					
Sibling					
Sibling					
Sibling					
Sibling					
Other					
Other					

How often do you exercise during a typical week? ______________________________

What exercise activities do you do? ______________________________

Describe your eating habits: ______________________________

____

Describe your energy level: ______________________________

Are there things about your relationship with food or exercise that you would like to change? ______________________________

____

How many hours do you sleep at night? ________ Do you feel rested during the day? ______________

How much do you nap during the day? __________ Anything else about your sleep? ______________

Are you presently taking any medications? ☐Yes ☐No If yes, please specify the medication and dosage (Include birth control, allergy medications, herbs, and over-the-counter medications): ______________________________

Please list any previous medications: ______________________________

Have any members of your family had chronic or acute physical/mental health concerns?

Family Member	**Problem**	**Current? (Y/N)**	**Past? (Y/N)**

Briefly describe anything else that you think is important for your counselor to know about your health and/or family history:

____

____

____

Continue to next page

SUBSTANCE USE:

Reminder: **Your answers are confidential. They are not part of your record and will not be seen by anyone outside the Counseling Center without your permission.**

Please check any caffeine products you use:

Coffee Espresso Soda Energy Drinks Tea Over-the-counter stimulants

How much per day? ______________________________

Do you use tobacco? Yes No If yes, how much? ______________________________

How often do you have a drink containing alcohol?

Never Monthly or less 2-4 times a month 2-3 times a week 4 or more times a week

How many drinks containing alcohol do you have on a typical day when you are drinking?

1-2 3-4 5-6 7-9 10 or more

How often during the last year have you found that you were not able to stop drinking once you started?

Never Less than monthly Monthly Weekly Daily or almost daily

How often during the last year have you been unable to remember what happened when you had been drinking?

Never Less than monthly Monthly Weekly Daily or almost daily

How often do you smoke marijuana?

Never Monthly or less 2-4 times a month 2-3 times a week 4 or more times a week

Daily (If daily, how many times per day?) ______________________________

Have you ever used substances other than alcohol or marijuana (including misuse of prescription meds)? Y N

If yes, drug(s) name(s): ______________________________

Frequency of use: ______________________________

Is there (past or current) misuse of alcohol, drugs or other substances by you? Yes No Or your family? Yes No

If yes, who and what substances? ______________________________

Have you ever been treated for a problem with drugs or alcohol? Yes No

Have you ever felt the need to reduce your alcohol or drug use? Yes No

Do you feel drinking or using drugs helps you manage your emotional issues and/or sleep? Yes No

Are you concerned about your relationship with drugs or alcohol? Yes No

Are you interested in talking about your relationship with drugs or alcohol? Yes No

Continue to next page

Please indicate how many times and the last time you had each of the following experiences:

	How Many Times	**The Last Time**
Purposely injured yourself without suicidal intent:	☐ Never ☐ 1 time ☐ 2-3 times ☐ 4-5 times ☐ More than 5 times	☐Never ☐ Within the last 2 weeks ☐ Within the last month ☐ Within the last year ☐ Within the last 1-5 years ☐ More than 5 years ago
Seriously considered attempting suicide:	☐ Never ☐ 1 time ☐ 2-3 times ☐ 4-5 times ☐ More than 5 times	☐Never ☐ Within the last 2 weeks ☐ Within the last month ☐ Within the last year ☐ Within the last 1-5 years ☐ More than 5 years ago
Made a suicide attempt:	☐ Never ☐ 1 time ☐ 2-3 times ☐ 4-5 times ☐ More than 5 times	☐Never ☐ Within the last 2 weeks ☐ Within the last month ☐ Within the last year ☐ Within the last 1-5 years ☐ More than 5 years ago
Caused serious physical injury to another person:	☐ Never ☐ 1 time ☐ 2-3 times ☐ 4-5 times ☐ More than 5 times	☐Never ☐ Within the last 2 weeks ☐ Within the last month ☐ Within the last year ☐ Within the last 1-5 years ☐ More than 5 years ago
Someone had sexual contact with you without your consent (e.g., you were afraid to stop what was happening, passed out, drugged, drunk, incapacitated, asleep, threatened or physically forced):	☐ Never ☐ 1 time ☐ 2-3 times ☐ 4-5 times ☐ More than 5 times	☐Never ☐ Within the last 2 weeks ☐ Within the last month ☐ Within the last year ☐ Within the last 1-5 years ☐ More than 5 years ago
Experienced harassing, controlling, and/or abusive behavior from another person (e.g., friend, family member, partner, or authority figure):	☐ Never ☐ 1 time ☐ 2-3 times ☐ 4-5 times ☐ More than 5 times	☐Never ☐ Within the last 2 weeks ☐ Within the last month ☐ Within the last year ☐ Within the last 1-5 years ☐ More than 5 years ago
Experienced a traumatic event that caused you to feel intense fear, helplessness, or horror:	☐ Never ☐ 1 time ☐ 2-3 times ☐ 4-5 times ☐ More than 5 times	☐Never ☐ Within the last 2 weeks ☐ Within the last month ☐ Within the last year ☐ Within the last 1-5 years ☐ More than 5 years ago

MORE ABOUT YOU

What do you see as your strengths?____

____

What do you do for fun?____

What do you hope to do when you graduate?____

Is there anything else that you feel is important for us to know? ____