Augsburg University

Center for Wellness & Counseling Personal Information Form

Last name	First name	MI	Today's Date
Name you prefer to be called	Date of Birth	Age	Cell Phone #
Permanent Address			Home Phone #
Preferred E-mail Address			Campus Box

May we contact you/leave a message at your phone number? Cell: ☐ yes ☐ no Home: ☐ yes ☐ no
May we contact you by e-mail? ☐ yes ☐ no May we write to you at your address? ☐ yes ☐ no

Have you received counseling in the past? ☐ yes ☐ no If yes, ☐ at Augsburg ☐ or off-campus
If yes, name of previous counselor: _____

Who referred you to counseling? _____

Emergency Contact (name, relationship to you, phone number): _____

College Status (check all that apply)
___First year ___Sophomore ___Junior ___Senior
___Day student ___Adult Undergraduate Program ___Graduate student
Major(s)_____

Are you a participant in: ___CLASS ___TRIO ___StepUP ___Conditional Admit Program ____Academic Skills Coaching

Relationship Status: ___Single ___In relationship ___Partnered, not married ___Married ___Divorced/Separated

Race/Ethnicity: (check all that apply)
___African-American/Black ___American Indian/Native American ___Asian/Asian-American
___Euro-American/White ___Hispanic/Latinx ___International student
___Other_____ ___Prefer not to respond

Gender Identity: ___Female ___Male ___Trans Man ___Trans Woman ___Gender Non-conforming ___Gender Questioning
Other_____ ___Prefer not to respond
Preferred pronouns (e.g., she/her/hers, he/him/his, they/theirs, etc.) _____

Sexual Orientation: ___Bisexual ___Gay ___Heterosexual ___Lesbian
___Questioning Other _____ ___Prefer not to respond

Residence: ___On Campus ___Off Campus
Living with: ___Alone ___Roommate(s) ___Parent/relative ___Partner ___Spouse ___Children

Enrollment: ☐ full-time ☐ part-time Current GPA (approximate):_____

Are you on academic probation? ☐ yes ☐ no Are you on social probation (current disciplinary action)? ☐ yes ☐ no

List current classes:

_____ _____

_____ _____

_____ _____

Are you employed? ☐ yes ☐ no If yes, how many hours per week? _____ Employer:_____

Religious Affiliation/Spiritual Identity: Family Background: _____ Current:_____

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

___academic difficulties
___alcohol/drug use
___anger
___anxiety
___attention/ADHD
___body image
___career concerns
___cultural/ethnic identity
___depression/low mood
___disturbing thoughts
___eating concerns
___emotional abuse
___faith/spiritual concerns
___family problems
___financial concerns
___gambling
___grief/loss
___internet usage concerns
___mood swings
___motivation/procrastination
___panic attacks
___physical abuse
___physical health problems
___relationship problems
___self-esteem
___self-injury
___sexual abuse
___sexual assault
___sexual concerns
___sexual harassment
___sexuality/sexual identity
___sleep problems
___social life/making friends
___stress
___suicidal thoughts
___test anxiety
___thoughts of harming others
___other concerns? _____

Are these concerns affecting your academic work? ☐ yes ☐ no

Please list below the people in your family:

Name	Relationship to you	Occupation
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please check if any of the following were present in your family environment growing up:

___physical abuse
___emotional/verbal abuse
___sexual abuse
___alcohol/drug problems
___mental health issues (depression, anxiety)
___none of the above

Please answer the following questions:

Do you use alcohol? ☐ yes ☐ no If yes, how frequently? ☐ daily ☐ several times a week ☐ weekly ☐ occasionally
How many drinks do you usually have?_____ Do you or others have a concern about your alcohol use? ☐ yes ☐ no
Do you use marijuana or other drugs? ☐ yes ☐ no How frequently? ☐ daily ☐ several times a week ☐ weekly ☐ occasionally
Have you ever been treated for chemical dependency? ☐ yes ☐ no If yes, treatment dates:_____

Have you ever been treated for an eating disorder? ☐ yes ☐ no If yes, treatment dates:_____
Do you or others have a concern about your eating? ☐ yes ☐ no

Do you have any current medical problems? ☐ yes ☐ no List:_____
Have you been diagnosed with a disability? ☐ yes ☐ no List:_____

Have you ever been hospitalized for psychiatric reasons? ☐ yes ☐ no
If yes, dates of hospitalization:_____ Reason for hospitalization: _____

Are you currently taking any medications for mental health concerns (e.g. depression, anxiety, ADHD)? ☐ yes ☐ no
List:_____ Prescribing doctor: _____

Do you have health insurance? ☐ yes ☐ no Insurer? (e.g. Health Partners, BCBS) _____

In your own words, please describe briefly what brings you in for counseling today:

_____

_____

_____