



PROVIDENCE
COLLEGE

Personal Counseling Center

Counselor seen today: _____

Today's Date: _____

STUDENT INFORMATION FORM

Name _____ Banner# _____ Preferred Name: _____

Local address _____
(include room # if on campus, & friar box #)

Permanent address _____

Cell # _____ Home # _____ Email _____

Date of Birth _____ Gender _____ Race/ethnic identity _____ Religious affiliation _____

Class year: Freshman _____ Sophomore _____ Junior _____ Senior _____ Grad _____ Other _____

GPA _____ Major _____ If employed, # hours/wk: _____

Referred by _____ Counseling here before? _____ If yes, with whom? _____

Emergency contact _____ Phone(s) _____ Relationship _____

All current medications (prescription and over the counter): _____

Medical conditions/concerns _____
(include concussion and seizure history)

Check any that apply: ROTC _____ Varsity athlete _____ Club sport _____ International student _____

STUDENT SURVEY

The following information can assist us in finding ways to be helpful to you. However, if you find you cannot or do not wish to answer a particular question, feel free to talk to the counselor about it instead. Anything you share is considered confidential health information and is not a part of your academic record.

Why are you coming here today?

Circle one number to indicate how upset this makes you feel: 1 (mildly) 2 3 4 5 (moderately) 6 7 8 9 10 (a lot)

How long have you had this (these) concern(s)? _____ Any negative impact on your academic work? _____

Please describe any recent events or experiences that may have contributed to your concern(s) _____

What do you hope to accomplish through coming to the Personal Counseling Center? _____

Over please 

How many meetings do you think would be helpful? _____

Have you ever been in counseling/treatment before? If so, please state when and what concerns were addressed:

Have you ever been hospitalized for mental health or substance abuse concerns? If so, please state when and where:

Who are the members in your immediate family and what are their ages?

Is there a history in your immediate or extended family of any diagnosed mental/emotional health issues? If so please list those diagnoses/issues (you do not need to list specific individuals):

Please list some of the things that you enjoy to do or that you find help to soothe you when you are upset:

Looking back over the ***past week***, how have you been doing in the following areas of your life?

Circle one number for each area.

Individually

(Personal well-being, health, mood)

Extremely poorly 1 2 3 4 5 6 7 8 9 10 Very well

Interpersonally

(Family, friends, close relationships)

Extremely poorly 1 2 3 4 5 6 7 8 9 10 Very well

Academically

(Attendance, keeping up with work, test grades, etc.)

Extremely poorly 1 2 3 4 5 6 7 8 9 10 Very well

Overall

(General sense of well-being)

Extremely poorly 1 2 3 4 5 6 7 8 9 10 Very well

Over please 

Please indicate if you have experienced the following in the last month and, approximately, how often.

	Not at all	1 – 3 times	4 – 7 times	Most days
Missed class				
Felt anxious				
Felt sad or depressed				
Thought about suicide				
Worried about my weight				
Felt very angry				
Drank alcohol				
Worried about career concerns				
Smoked marijuana				
Used other recreational drugs				
Withdrew from others				
Had difficulty sleeping				
Had racing thoughts				
Had difficulty concentrating				
Trouble keeping up with schoolwork				
Had thoughts of physically hurting another person				
Felt lonely				
Had difficulty with eating				
Gambled				
Felt self conscious				
Sometimes saw or heard things other people didn't				
Peer concerns				
Experienced a traumatic event				
Financial worries				
Felt unusually tired				
Had intrusive thoughts				
Worried about sexual concerns				
Thought about death				
Felt unmotivated				
Felt hopeless				
Regretted something I did while using substances				
Felt paranoid				
Worried about a romantic relationship				
Experienced a significant loss				
Thought about physically harming myself/harmed myself				
Worried about my family/had family concerns				
Took someone else's prescription drugs				
Felt controlled or harassed by another person				
Thought about leaving school				
Exercised				
Had a fun time with friends				
Felt capable and in charge of my life				
Engaged in prayer or meditation				
Felt confident				

Over please 

Please block off times that you are available to meet with a counselor.

TIME	Monday	Tuesday	Wednesday	Thursday	Friday
8:30	A or B	C	C	A or D	C
9:30	E or B	F	F	A or D	F
10:30	E or B	G	G	E or D	G
11:30	H	K	H	K	H
12:30	I	L	I	L	I
1:30	J		J		J
2:30	M, N, or P	N or Q	M	N, O, or R	M or S
3:30			COMMON MEETING TIME	N, O, or R	M or S
4:30	T	U or V	U or W		
5:30					

- Time series C, F, G, H, I, J, and M – 3 times per week for 50 minutes
- Time series A, E, K, L, N, O, and U – 2 times per week for 75 minutes
- Time series B, D, P, Q, R, S, T, V, and W – 1 time per week for 150 minutes