

**University of Tennessee Counseling Center  
Initial Consultation Form**

**Date:** \_\_\_\_\_  
**UT ID#:** \_\_\_\_\_  
 I am  
 **Not in Crisis**  
 **In Crisis**

**First Name:** \_\_\_\_\_ **Middle:** \_\_\_\_\_ **Last:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Current Age:** \_\_\_\_\_ **Gender:**  
 Male  Female  Transgender

**Local Address:**  
 \_\_\_\_\_  
 (street) (city) (state) (zip code)

**Permanent Address:**  
 \_\_\_\_\_  
 (street) (city) (state) (zip code)

**Preferred Phone #:** \_\_\_\_\_ **Other Phone #:** \_\_\_\_\_  
**E-mail:** \_\_\_\_\_

**Permission to Contact:** Preferred Phone Other Phone E-mail  
 Yes / No Yes / No Yes / No

Availability: Please cross out **ALL** times that you are **unavailable**, so that counselors can accommodate you in a timely manner.

	8:00	9:00	10:00	11:00	Noon	1:00	2:00	3:00	4:00	5:00
<b>Monday</b>										
<b>Tuesday</b>										
<b>Wednesday</b>										
<b>Thursday</b>										
<b>Friday</b>										

**Who referred you to the Counseling Center?**

Self  On-Line screenings  Judicial/Dean of Students  
 Family  Friends: \_\_\_\_\_  Residence Life  
 Faculty: \_\_\_\_\_  Health Center  Other: \_\_\_\_\_

I  give,  do not give, permission to inform this person or office of my attendance.

\_\_\_\_\_  
 Signature

**What do you hope to gain through meeting with a counselor with regard to your personal problems / concerns? How will you know when things are better?**

\_\_\_\_\_

<p><b>Ethnicity:</b></p> <input type="checkbox"/> African-American / Black <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Arab American / Arab / Persian <input type="checkbox"/> Asian American / Asian <input type="checkbox"/> East Indian <input type="checkbox"/> European American / White / Caucasian <input type="checkbox"/> Hispanic / Latino / Latina <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Multi-racial <input type="checkbox"/> Prefer not to answer <input type="checkbox"/> Other (please specify): <input type="checkbox"/> If you would like to, please further describe your racial, cultural, ethnic, or regional identity: _____ _____	<p><b>What is your country of origin?</b></p> <p><b>Are you an International Student?</b></p> <input type="checkbox"/> Yes <input type="checkbox"/> No	<p><b>Relationship Status:</b></p> <input type="checkbox"/> Single <input type="checkbox"/> Serious dating or committed relationship <input type="checkbox"/> Married <input type="checkbox"/> Civil union, domestic partnership, or equivalent <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <p><b>Sexual Orientation</b></p> <input type="checkbox"/> Heterosexual <input type="checkbox"/> Gay <input type="checkbox"/> Lesbian <input type="checkbox"/> Bisexual <input type="checkbox"/> Questioning <input type="checkbox"/> Prefer not to Answer
<p><b>Current Academic Status:</b></p> <input type="checkbox"/> Freshman / First-year <input type="checkbox"/> Sophomore <input type="checkbox"/> Junior <input type="checkbox"/> Senior <input type="checkbox"/> Graduate / professional degree student <input type="checkbox"/> *Non-student <input type="checkbox"/> *High school student taking college classes <input type="checkbox"/> *Non-degree student <input type="checkbox"/> *Faculty/staff <input type="checkbox"/> Other (please specify): _____	<p><b>Academic Program:</b></p> <p><b>Major:</b> _____</p> <p><b>GPA:</b> _____</p> <p><b>Credits this semester:</b> _____</p> <p><b>Did you transfer from another campus/institution to UTK?</b></p> <input type="checkbox"/> Yes (when / where?) _____ <input type="checkbox"/> No	<p>Please indicate your <b>level of involvement</b> in extra-curricular activities (e.g., sports, clubs, student government.)</p> <input type="checkbox"/> None <input type="checkbox"/> Occasional participation <input type="checkbox"/> One regularly attended activity <input type="checkbox"/> Two regularly attended activities <input type="checkbox"/> Three or more regularly attended activities <p>Do you participate on an athletic team that competes with other colleges or universities?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <p>Are you a member of ROTC?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No
<p><b>What kind of housing do you currently have?</b></p> <input type="checkbox"/> On-campus residence hall/apartment <input type="checkbox"/> On/off campus fraternity/sorority <input type="checkbox"/> Off-campus cooperative housing <input type="checkbox"/> Off-campus apartment/house <input type="checkbox"/> Other (please specify): _____	<p><b>With whom do you live?</b> (check all that apply)</p> <input type="checkbox"/> Alone <input type="checkbox"/> Spouse, partner, or significant other <input type="checkbox"/> Roommate(s) <input type="checkbox"/> Children <input type="checkbox"/> Parent(s) or guardian(s) <input type="checkbox"/> Family other <input type="checkbox"/> Other (please specify): _____	<p><b>Please estimate the number of hours per week you are actively involved in organized extra-curricular activities</b> (e.g., sports, clubs, student government, etc.):</p> _____ Hours/wk <p><b>What is the average number of hours you work per week during the school year</b> (paid employment only)?</p> _____ Hours/wk
<p><b>College:</b></p> <input type="checkbox"/> Agricultural Sciences & Natural Resources <input type="checkbox"/> Architecture & Design <input type="checkbox"/> Arts & Sciences <input type="checkbox"/> Business Administration <input type="checkbox"/> Communications & Information <input type="checkbox"/> Education, Health & Human Services <input type="checkbox"/> Engineering <input type="checkbox"/> Graduate School <input type="checkbox"/> Law <input type="checkbox"/> Nursing <input type="checkbox"/> Social Work <input type="checkbox"/> Veterinary Medicine	<p><b>Graduate or Professional Degree Program:</b></p> <input type="checkbox"/> Post-Baccalaureate <input type="checkbox"/> Masters <input type="checkbox"/> Doctoral degree <input type="checkbox"/> Law <input type="checkbox"/> Medical <input type="checkbox"/> Pharmacy <input type="checkbox"/> Veterinary Medicine <input type="checkbox"/> Not Applicable <input type="checkbox"/> Other: _____	<p><b>What year are you in your graduate/professional program?</b></p> <input type="checkbox"/> 1 <sup>st</sup> year <input type="checkbox"/> 2 <sup>nd</sup> year <input type="checkbox"/> 3 <sup>rd</sup> year <input type="checkbox"/> 4 <sup>th</sup> year <input type="checkbox"/> 5 <sup>th</sup> + year

<p><b>Parent's Relationship:</b></p> <p><input type="checkbox"/> Never Married  <input type="checkbox"/> Married  <input type="checkbox"/> Divorced  <input type="checkbox"/> Separated  <input type="checkbox"/> Widowed</p> <p>If applicable, continue below:</p> <table border="0"> <tr> <td><b>Mom</b></td> <td><b>Dad</b></td> </tr> <tr> <td><input type="checkbox"/> Single</td> <td><input type="checkbox"/> Single</td> </tr> <tr> <td><input type="checkbox"/> Remarried</td> <td><input type="checkbox"/> Remarried</td> </tr> <tr> <td><input type="checkbox"/> Committed Relationship</td> <td><input type="checkbox"/> Committed Relationship</td> </tr> <tr> <td><input type="checkbox"/> Civil Union/Domestic Relationship or Equivalent</td> <td><input type="checkbox"/> Civil Union/Domestic Relationship or Equivalent</td> </tr> </table>	<b>Mom</b>	<b>Dad</b>	<input type="checkbox"/> Single	<input type="checkbox"/> Single	<input type="checkbox"/> Remarried	<input type="checkbox"/> Remarried	<input type="checkbox"/> Committed Relationship	<input type="checkbox"/> Committed Relationship	<input type="checkbox"/> Civil Union/Domestic Relationship or Equivalent	<input type="checkbox"/> Civil Union/Domestic Relationship or Equivalent	<p><b>Religious or Spiritual Preference:</b></p> <p><input type="checkbox"/> Agnostic  <input type="checkbox"/> Atheist  <input type="checkbox"/> Buddhist  <input type="checkbox"/> Christian  <input type="checkbox"/> Confucian  <input type="checkbox"/> Hindu  <input type="checkbox"/> Jewish  <input type="checkbox"/> Muslim  <input type="checkbox"/> No Preference  <input type="checkbox"/> Prefer not to answer  <input type="checkbox"/> Other: _____</p>	<p><b>Primary Source of Income:</b> (Check all that apply)</p> <p><input type="checkbox"/> Family  <input type="checkbox"/> Job  <input type="checkbox"/> Financial Aid  <input type="checkbox"/> Savings  <input type="checkbox"/> Other: _____</p>
<b>Mom</b>	<b>Dad</b>											
<input type="checkbox"/> Single	<input type="checkbox"/> Single											
<input type="checkbox"/> Remarried	<input type="checkbox"/> Remarried											
<input type="checkbox"/> Committed Relationship	<input type="checkbox"/> Committed Relationship											
<input type="checkbox"/> Civil Union/Domestic Relationship or Equivalent	<input type="checkbox"/> Civil Union/Domestic Relationship or Equivalent											

**Do you have a diagnosed and documented disability?** (check all that apply)

<input type="checkbox"/> Attention Deficit/Hyperactivity	<input type="checkbox"/> Mobility Impairments	<input type="checkbox"/> Psychological Disorder/Condition
<input type="checkbox"/> Deaf or Hard of Hearing	<input type="checkbox"/> Neurological Disorders	<input type="checkbox"/> Visual Impairments
<input type="checkbox"/> Learning Disorders	<input type="checkbox"/> Physical/health related Disorders	<input type="checkbox"/> Other (please specify):

<p><b>Are you the first generation in your family to attend college?</b></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><b>How would you describe your financial situation <u>right now</u>?</b></p> <p><input type="checkbox"/> Always stressful  <input type="checkbox"/> Often stressful  <input type="checkbox"/> Sometimes stressful  <input type="checkbox"/> Rarely stressful  <input type="checkbox"/> Never stressful</p>	<p><b>How would you describe your financial situation <u>while growing up</u>?</b></p> <p><input type="checkbox"/> Always stressful  <input type="checkbox"/> Often stressful  <input type="checkbox"/> Sometimes stressful  <input type="checkbox"/> Rarely stressful  <input type="checkbox"/> Never stressful</p>
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<p><b>Have you ever been, or are you currently, enlisted in any branch of the US military (active duty, veteran, national guard or reserves)?</b></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><b>Did your military experiences include any traumatic or highly stressful experiences which continue to bother you? (e.g., war, combat, injuries, death, natural disasters, foreign deployment, etc.)</b></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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<p><b>Have you ever missed classes, performed below your abilities in class or on the job, done something you've later regretted, or other problems that resulted from your use of alcohol or another substance?</b></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><b>Think back over the last two weeks. How many times have you had:</b></p> <p><b>For males:</b> five or more drinks in a row?  <b>For females:</b> four or more drinks in a row?</p> <p><input type="checkbox"/> None  <input type="checkbox"/> Once  <input type="checkbox"/> Twice  <input type="checkbox"/> 3 to 5 times  <input type="checkbox"/> 6 to 9 times  <input type="checkbox"/> 10 or more times</p>
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**Please indicate how much you agree with these statements:**  
"I get the emotional help and support I need from my ..."

<p><b>Family</b></p> <p><input type="checkbox"/> Strongly disagree  <input type="checkbox"/> Somewhat disagree  <input type="checkbox"/> Neutral  <input type="checkbox"/> Somewhat agree  <input type="checkbox"/> Strongly agree</p>	<p><b>Social Network (friends &amp; acquaintances)</b></p> <p><input type="checkbox"/> Strongly disagree  <input type="checkbox"/> Somewhat disagree  <input type="checkbox"/> Neutral  <input type="checkbox"/> Somewhat agree  <input type="checkbox"/> Strongly agree</p>
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▶▶ **Continue to next page** ▶▶

Please provide the following information:

Name	Relationship	Age	Education	Occupation
	Father			
	Mother			
other person important to you:				
other person important to you:				

How many siblings do you have? \_\_\_\_\_ Brother(s) (ages: \_\_\_\_\_) \_\_\_\_\_ Sister(s) (ages: \_\_\_\_\_)

Please list any serious medical conditions that you have or believe that you might have:

Are you currently taking any medication? Yes No Please list: \_\_\_\_\_

Including yourself, please list family members by relationship whom you believe had/have a serious emotional or mental problem or alcoholism/drug abuse: (e.g., mother's father: depression).

Family Member	Emotional or mental problem or alcoholism/drug abuse
SELF	

Briefly describe anything else that you think is important for your counselor to know about your health / status at this time:

Previously used our services? Yes No If yes, when: \_\_\_\_\_

Have you had prior counseling elsewhere? Yes No If yes, # of sessions/months: \_\_\_\_\_

With: \_\_\_\_\_ When: \_\_\_\_\_ Where: \_\_\_\_\_

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Please indicate if/when you have had the following experiences: <i>check one per row ►</i>	Never	Prior to college	After starting college	Both
	Attended counseling for mental health concerns			
Taken a prescribed medication for mental health concerns				
Been hospitalized for mental health concerns				
Felt the need to reduce your alcohol or drug use				
Received treatment for alcohol or drug use				
Purposely injured yourself without suicidal intent (e.g., cutting, hitting, burning, hair pulling, etc.)				
Seriously considered attempting suicide				
Made a suicide attempt				
Seriously considered injuring another person				
Intentionally injured another person				
Had unwanted sexual contact(s) or experience(s)				
Experienced harassing, controlling, and/or abusive behavior from another person (e.g., friend, family member, partner, or authority figure)				
Been hit, punched, slapped, kicked, or otherwise physically harmed by a person (e.g., friend, family, partner, or authority figure) with cruel or malicious intent				
	Yes		No	
Have you experienced, witnessed, or learned of a traumatic event(s) that involved actual or threatened death or serious injury, or a threat to the physical integrity of yourself or others?				
If you selected "Yes" for the previous question, did the traumatic event(s) cause you to feel intense fear, helplessness or horror?				
If you selected "Yes" for either of the previous two questions, please briefly describe the event(s):				

This questionnaire contains items that describe how some people feel and act. Please read each item carefully. Please indicate how well each item describes you during the past two weeks including today. Although some questions appear to address general life issues, please respond based on your current thoughts and feelings about these issues. Circle the number indicating how well each item describes you during the past two weeks, from **not at all (0) to extremely well (4)**. Circle one response for each item and do not leave any blank. Please indicate honestly how well each item describes you during the past two weeks including today. Please check the box if you might want help with this issue.

	Not at all	Extremely Well	Req. Help
1. I get sad or angry when I think of my family	0	1 2 3 4	<input type="checkbox"/>
2. I have a lot of energy	0	1 2 3 4	<input type="checkbox"/>
3. I am shy around others	0	1 2 3 4	<input type="checkbox"/>
4. There are many things I am afraid of	0	1 2 3 4	<input type="checkbox"/>
5. My heart races for no good reasons	0	1 2 3 4	<input type="checkbox"/>
6. I feel out of control when I eat	0	1 2 3 4	<input type="checkbox"/>
7. Spirituality and religion are integral parts of my identity	0	1 2 3 4	<input type="checkbox"/>
8. I enjoy my classes	0	1 2 3 4	<input type="checkbox"/>
9. I feel that my family loves me	0	1 2 3 4	<input type="checkbox"/>
10. I feel disconnected from myself	0	1 2 3 4	<input type="checkbox"/>
11. I don't enjoy being around people as much as I used to	0	1 2 3 4	<input type="checkbox"/>

►► Continue to next page ►►

	Not at all		Extremely Well			Req. Help
12. I find my spirituality to be an important source of support	0	1	2	3	4	<input type="checkbox"/>
13. I feel isolated and alone	0	1	2	3	4	<input type="checkbox"/>
14. My family gets on my nerves	0	1	2	3	4	<input type="checkbox"/>
15. I lose touch with reality	0	1	2	3	4	<input type="checkbox"/>
16. I think about food more than I would like to	0	1	2	3	4	<input type="checkbox"/>
17. I am anxious that I might have a panic attack while in public	0	1	2	3	4	<input type="checkbox"/>
18. I feel confident that I can succeed academically	0	1	2	3	4	<input type="checkbox"/>
19. I become anxious when I have to speak in front of audiences	0	1	2	3	4	<input type="checkbox"/>
20. I often feel outside my body	0	1	2	3	4	<input type="checkbox"/>
21. I have sleep difficulties	0	1	2	3	4	<input type="checkbox"/>
22. My thoughts are racing	0	1	2	3	4	<input type="checkbox"/>
23. I am satisfied with my body shape	0	1	2	3	4	<input type="checkbox"/>
24. I feel worthless	0	1	2	3	4	<input type="checkbox"/>
25. My family is basically a happy one	0	1	2	3	4	<input type="checkbox"/>
26. I am dissatisfied with my weight	0	1	2	3	4	<input type="checkbox"/>
27. I feel helpless	0	1	2	3	4	<input type="checkbox"/>
28. I use drugs more than I should	0	1	2	3	4	<input type="checkbox"/>
29. I eat too much	0	1	2	3	4	<input type="checkbox"/>
30. I drink alcohol frequently	0	1	2	3	4	<input type="checkbox"/>
31. I have spells of terror or panic	0	1	2	3	4	<input type="checkbox"/>
32. I am enthusiastic about life	0	1	2	3	4	<input type="checkbox"/>
33. When I drink alcohol I can't remember what happened	0	1	2	3	4	<input type="checkbox"/>
34. I feel tense	0	1	2	3	4	<input type="checkbox"/>
35. When I start eating I can't stop	0	1	2	3	4	<input type="checkbox"/>
36. I have difficulty controlling my temper	0	1	2	3	4	<input type="checkbox"/>
37. I am easily frightened or startled	0	1	2	3	4	<input type="checkbox"/>
38. I diet frequently	0	1	2	3	4	<input type="checkbox"/>
39. I make friends easily	0	1	2	3	4	<input type="checkbox"/>
40. I sometimes feel like breaking or smashing things	0	1	2	3	4	<input type="checkbox"/>
41. I have unwanted thoughts I can't control	0	1	2	3	4	<input type="checkbox"/>
42. My mind is not working the way that it used to	0	1	2	3	4	<input type="checkbox"/>
43. There is a history of abuse in my family	0	1	2	3	4	<input type="checkbox"/>
44. I experience nightmares or flashbacks	0	1	2	3	4	<input type="checkbox"/>
45. I feel sad all the time	0	1	2	3	4	<input type="checkbox"/>
46. I am concerned that other people do not like me	0	1	2	3	4	<input type="checkbox"/>
47. I wish my family got along better	0	1	2	3	4	<input type="checkbox"/>
48. I get angry easily	0	1	2	3	4	<input type="checkbox"/>
49. I feel uncomfortable around people I don't know	0	1	2	3	4	<input type="checkbox"/>
50. I feel irritable	0	1	2	3	4	<input type="checkbox"/>
51. I have thoughts of ending my life	0	1	2	3	4	<input type="checkbox"/>
52. I feel self conscious around others	0	1	2	3	4	<input type="checkbox"/>
53. I purge to control my weight	0	1	2	3	4	<input type="checkbox"/>
54. I drink more than I should	0	1	2	3	4	<input type="checkbox"/>
55. I feel guilty	0	1	2	3	4	<input type="checkbox"/>
56. I enjoy getting drunk	0	1	2	3	4	<input type="checkbox"/>
57. I am not able to concentrate as well as usual	0	1	2	3	4	<input type="checkbox"/>
58. I am afraid I may lose control and act violently	0	1	2	3	4	<input type="checkbox"/>
59. It's hard to stay motivated for my classes	0	1	2	3	4	<input type="checkbox"/>
60. I feel comfortable around other people	0	1	2	3	4	<input type="checkbox"/>
61. I like myself	0	1	2	3	4	<input type="checkbox"/>
62. Religion plays a positive role in my life	0	1	2	3	4	<input type="checkbox"/>
63. I have done something I have regretted because of drinking	0	1	2	3	4	<input type="checkbox"/>
64. I frequently get into arguments	0	1	2	3	4	<input type="checkbox"/>
65. I find that I cry frequently	0	1	2	3	4	<input type="checkbox"/>
66. I am unable to keep up with my schoolwork	0	1	2	3	4	<input type="checkbox"/>
67. I have a strong cultural/ethnic identity	0	1	2	3	4	<input type="checkbox"/>
68. I have thoughts of hurting others	0	1	2	3	4	<input type="checkbox"/>
69. The less I eat, the better I feel about myself	0	1	2	3	4	<input type="checkbox"/>
70. I feel that I have no one who understand me	0	1	2	3	4	<input type="checkbox"/>