

Hungkuang University Counseling Center Application for Individual Counseling

Date: YYYY/MM/DD

Name		Gender	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other			Student ID		Telephone	(Home)
Unit/Department		Class			D.O.B.	/ /	ne	(Cell)	
Current residence					Home address				
Marital status	<input type="checkbox"/> Not married <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Other				E-Mail	(Primary email)			
Advisor					Emergency contact		Cell:		
Reason for consultation	<input type="checkbox"/> Voluntary visit <input type="checkbox"/> Teacher referral <input type="checkbox"/> Student referral <input type="checkbox"/> Center invitation <input type="checkbox"/> Other _____ Referred by: _____								
Planned topics of discussion (please rank the selected topics as 1, 2, and 3)	<input type="checkbox"/> Self-exploration and self-growth <input type="checkbox"/> Interpersonal relationships <input type="checkbox"/> Romantic relationships <input type="checkbox"/> Learning problems <input type="checkbox"/> Career exploration and planning <input type="checkbox"/> Family relationships <input type="checkbox"/> Psychological testing <input type="checkbox"/> Mental disorder or inclinations <input type="checkbox"/> Emotional distress <input type="checkbox"/> Life adaptation <input type="checkbox"/> Physiological health <input type="checkbox"/> Other _____								
Please think carefully about the extent to which these issues have troubled or distressed you over the past two weeks (including today) and select the option that best reflects your feelings.	Not all Somewhat Moderately Strongly Very strongly						If you answered 1 or higher for Question 6		
	1. Difficulty sleeping	0	1	2	3	4	<input type="checkbox"/> I have had thoughts about self-harm but would not act on them <input type="checkbox"/> I have a clear plan for self-harm <input type="checkbox"/> I have self-harmed in the following manner: _____ _____		
	2. Feelings of unease	0	1	2	3	4			
	3. Easily upset or angry	0	1	2	3	4			
	4. Feeling blue or feeling low	0	1	2	3	4			
	5. Feeling inferior to others	0	1	2	3	4			
6. Have had thoughts of suicide	0	1	2	3	4				
Psychiatric medical history	<input type="checkbox"/> No history <input type="checkbox"/> Yes; hospital name: _____ Physician diagnosis: _____					Are you currently taking psychiatric medication?		<input type="checkbox"/> No <input type="checkbox"/> Yes	

