Intake Form

Lawrence Technological University
Clinical Counseling Services

(Please Print)

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

Address: ____
(Street) (Apt. #)

____
(City or Town) (State) (Zip Code)

Cell #:		**Primary Email**:	

Home/School Phone #: ____________________ **Student #**: ____________

Male: ________ **Female**: ________ **Grade Level**: __________ **Age**: ________

GPA:		**Marital Status:**		**Single**		**Married**		**Divorced**	

Referred By: ____

Who should be contacted in case of emergencies?

____
(Name) (Relationship) (Phone #)

What brings you to the Counseling Office at this time?

What outcome would you like from our services?

Have you seen a counselor/social worker/psychologist before?

	Yes		**No**	

If yes, please list provider and dates:						
Provider:						
Dates:	**from**		**to**			
Notes:						
Have you ever been hospitalized?		**Yes**		**No**		
Have you had suicidal ideation or suicide attempts?		**Yes**		**No**		
Do you have any medical conditions?		**Yes**		**No**		
Please Describe:						
What is your current living arrangement?						
Are you taking any medications at this time?		**Yes**		**No**		
If yes, please describe:						
Do you have medical insurance?		**Yes**		**No**		
If yes, what kind?						