

**Westmont College Counseling Center
Confidential Information Form**

Welcome to the Westmont College Counseling Center! We ask that you please fill out the following information for the counselor who will be talking with you. If you are uncomfortable responding in writing to a question, you may skip it. The information will be kept in confidence in accordance with the Counseling Center policy.

Name: _____ Today's Date: _____

Birth Date: _____ Age: _____ Sex: ___ Female ___ Male

Ethnicity: (Please check all that apply)

___ African American ___ Asian American ___ Caucasian ___ Hispanic

___ Middle Eastern ___ Multiracial ___ Native American ___ Pacific Islander

Relationship Status: ___ Single ___ Dating ___ Engaged ___ Married ___ Divorced

Westmont Residence (Residence hall or off campus address) _____

Home/Permanent Address _____

Cell Phone Number: _____ Email Address: _____

Do we have permission to contact you by: ___ Email ___ Cell Phone?

In case of an emergency contact: (Name/Relationship) _____

Emergency contact phone number: _____

Class level: _____ Major: _____

How many years (including now) have you attended Westmont? _____

Transfer Student? ___ If yes, from where did you transfer? _____

What off-campus programs have you been on? _____

Currently experiencing any academic difficulties? _____

Vocational goals: _____

Religious background/orientation: _____

Activities involved in on campus/in community:

Counseling Concerns

How did you first hear about the Westmont Counseling Center? Who referred you?

Briefly describe the concerns that led you to come to the Counseling Center:

Please rate the degree of distress these concerns are currently causing you by circling the appropriate number.

Mild distress 1 2 3 4 5 6 7 8 9 10 Extreme distress

How long have these concerns been causing you this distress? _____

Are you currently suicidal? Yes No Have you ever been suicidal? Yes No

If yes to either of the above, please describe:

Have you had any previous counseling? Yes No If yes, please indicate when, how long, and with whom. Were there any medications prescribed in conjunction with counseling?

Are you currently taking prescribed medication? Yes No If yes, please indicate what medication, the dose, and how long you have been taking the medication.

What would you like to focus on in counseling?

What would you like to be different about yourself at the end of your time in counseling?

Medical Information

Are you currently seeing a physician for any medical condition? Yes No
If yes, please briefly describe the condition and treatment:

Who is your primary care physician? _____

What is your primary medical insurance carrier? _____

Have you ever been hospitalized? If so, when and for what?

Do you have any allergies to medication or food? If yes, please describe:

Please describe:

1. Sleep patterns (# of hours, difficulty sleeping?):

2. Eating habits (frequency, kinds of food, attitude towards food):

3. Exercise (how often, type):

Are you currently using any substance (alcohol, drugs, etc.) in a manner that concerns you or others who know you? ___ Yes ___ No If yes, please briefly describe.

Has this been an issue in the past? ___ Yes ___ No If yes, please describe:

Family Information

Parents' Marital Status:

If you have brothers and sisters, please list in birth order (including yourself):

Has anyone in your family had an emotional/behavioral disorder, psychiatric illness or substance abuse problem?

Please describe any issues in your family that have caused you concern in the past or present:

Finally, are there any other significant issues that you can think of that have affected you in your personal development?

Thank you!