University Counseling Services
Truman State University
Intake Information

Today's Date: _____

Patient Demographic Information

Legal First Name: _____ Legal Last Name: _____

Name You Go By: _____ Date of Birth: _____

Social Security Number: _____ Gender Assigned at Birth: _____

Gender Identity: _____ Pronouns: _____ Sexual Orientation: _____

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black ☐ Hispanic or Latino ☐ White

☐ Prefer not to answer ☐ Not listed (Please specify): _____

Phone Number: _____ Is it ok if we leave a message? ☐ Yes ☐ No

Is it okay if we text you? ☐ Yes ☐ No

Email Address: _____ (Please list an email you check regularly)

(Email is our primary method of communication. If you are uncomfortable receiving emails from our office, please let us know and we will update your information.)

Current Kirksville Address: _____

(For on campus, please list Hall and Room Number)

Permanent Address: _____

In Case of Emergency, please notify: Name:_____

Relationship:_____

Address:_____

Phone Number: _____

☐ Use the name and pronouns I go by when communicating with this emergency contact.

☐ Use my legal name to refer to me with this emergency contact.

Who is your Primary Care Provider/Prescriber? _____

Are you taking any medications either over-the-counter or prescribed by a physician or psychiatrist?

If yes, please list medications: _____ How did you hear about UCS? _____ Do you have any significant others, family, or others you know that are currently receiving services at UCS? If so, who? (We use this information to assess for conflicts of interest when assigning therapists.)

_____

Are you registered with the Disability Services Office at Truman as having a disability? ☐ Yes ☐ No

If YES, please explain: _____

REASON FOR SEEKING TREATMENT

Please briefly describe the problems you are experiencing:

_____

_____

Have you ever had previous therapy/counseling of any kind? □ Yes □ No If yes, when, with whom, and for how long?_____

Do you have an idea of which counselor you would like to see?_____

(Use the QR code to view counselor bios)

Do you have a preference of: ☐ In Person Therapy ☐ Virtual Therapy ☐ No Preference

☐ Male Therapist ☐ Female Therapist ☐ No Preference

(Efforts will be made to accommodate the above preferences when possible, however not guaranteed.)

Which days/times work best in your schedule? _____

Please check all of the items below that describe your situation:

□ Aggression, violence □ Anxiety, nervousness □ Financial trouble □ Guilt □ Failure □ Anger, hostility, irritability
□ Childhood issues □ Fears, phobia □ Fatigue, tiredness, low energy □ Inferiority feelings □ Irresponsibility □ Loneliness
□ Panic or anxiety attacks □ Mood swings □ Withdrawal, isolation □ Sleep problems □ Relationships problems □ Self-neglect
□ Judgment problems, risk taking □ School problems □ Delusions (false ideas) □ Stress and tension □ Emptiness
□ Attention, concentration, distractibility □ Depression, sadness, crying □ Procrastination, lack of motivation □ Perfectionism
□ Spiritual, religious, moral, ethical issues □ Eating problems – overeating, undereating □ Thought disorganization and confusion
□ Compulsions and/or obsessions (thoughts or actions that repeat themselves) □ Impulsiveness, loss of control, outbursts
□ Decision-making, indecision, putting off decisions □ Grieving, mourning, deaths, losses, breakup
□ Sexual issues, dysfunctions, conflicts, identity issues □ Abuse/trauma – physical, sexual, emotional, neglect

Do you currently have thoughts of harming yourself? □ Yes □ No

Have you in the past? □ Yes □ No If Yes, how long ago? _____

Do you currently have thoughts of wishing you were dead? □ Yes □ No

Do you currently have urges to hurt, harm, or kill someone else? □ Yes □ No If yes, whom? _____

Have you ever seriously considered suicide or felt like harming someone else? □ Yes □ No

If yes, please explain: _____

If yes to any of the above, do you need a crisis appointment? □ Yes □ No

Anything else you would like to share:

_____

_____

By signing below, I certify that all information submitted is correct to the best of my knowledge.

Patient Signature: _____ Date: _____

Witness (CFM Representative): _____ Date: _____

University Counseling Services

Truman State University Financial Intake Information

Today's Date: _____

First Name: _____ Last Name: _____ Date of Birth: ___/___/_____

Please initial one of the three options below BEFORE signing below:

_____ I decline to provide insurance information or do not have insurance. I have completed the sliding scale paperwork.

_____ I am choosing to utilize my insurance and have also completed the sliding scale paperwork.

(The sliding scale is part of the intake process and will need to be completed and returned prior to being scheduled)

Insurance Name: _____ Member ID: _____

Phone Number:_____ Group Number:_____

By signing below, I acknowledge that I have been made aware of how the billing for my UCS services works and have been notified of financial assistance options that are available to me.

Signature: _____ **Date:_____**