

UMPQUA COMMUNITY COLLEGE
LIFE COACH
CONFIDENTIAL CLIENT DATA SHEET

The following will help us to serve you better. As with all information you share with your life coach, this information is treated with professional confidentiality. Please contact us if this information changes.

Please Print and complete all information. Thank you.

Today's Date: _____

Last Name First Name Middle Initial

Date of Birth Age UCC Student ID#

Mailing Address City State Zip Code

Please fill in below the number(s) at which we may call you (note that cell phones may not be secure):

Cell Phone Message Home Home Phone

May we leave a message at the numbers above? Yes No

Are you currently enrolled at UCC? Yes No

Partnership Status:

Single/Not in a relationship Separated/Divorced Dating
 Widowed Married/Life partner Other: _____

Length of relationship: _____ Number of dependents: _____

Are you currently employed? Yes If yes, how many hours per week? _____ No

Do you have health insurance? Yes No

Are you currently under the care of a mental health professional? (e.g., counselor, psychologist, psychiatrist, etc.)

Yes No

If yes, please list your diagnosis or reason for seeking treatment: _____

Have you received counseling in the past? Yes No When was your last appointment? _____

If yes, please list your diagnosis or reason for seeking treatment: _____

Please list any medical or psychological conditions you may have: _____

Please list any medications you are currently taking: _____

Intake Checklist

Please check items causing you distress today. This list will assist your counselor in making a complete assessment of your concerns in order to be the most helpful to you.

Interpersonal Concerns

- Loneliness
- Assertiveness problem (Can't speak up/say no)
- Difficulty trusting other people
- Homesickness
- Relationship problem(s)
- Conflict with roommate or friend
- Conflict with parents or family members

Mood Symptoms

- Suicidal feelings/thoughts
- Cutting or self-injury
- Depressed mood
- Hopelessness
- Guilt
- Crying
- Mood fluctuations or sudden shifts
- Anger/Irritability/hostile feelings

Alcohol, Drug, and Addiction Concerns

- Concerned about my alcohol use
- Concerned about my drug use
- Family alcohol or drug problem
- Gambling
- Other _____

Anxiety and Stress-related symptoms

- PTSD
- Anxious or nervous
- Stress or unable to relax
- Sleep difficulties
- Worrying
- Panic Attacks
- Fears/Phobias
- Obsession/uncontrollable thoughts
- Performance/test anxiety

- Attention/concentration problems
- Perfectionism
- Procrastination or motivation problems

Recent loss

- Death
- Relationship ending

Trauma

- Incidence of physical or sexual abuse
- Victim of other violence
- Traumatic event

Eating and body image concerns

- Weight/body image
- Appetite problems
- Over or under eating
- Purging (vomiting, laxatives, over exercising)

Identity concerns

- Feeling lost or uncertain about who I am
- Self-esteem/self-confidence
- Sexual identity/orientation concerns
- Racial/ethnic or cultural identity issues
- Religious/spiritual concerns

Other

- Hearing voices
- Seeing things that aren't there
- Concerns that others can hear your thoughts or that you can hear theirs.

(please identify)

On a scale of 1-10, with zero being no interference and ten being severe interference, please estimate how much your problem(s) are affecting the following areas of your life:

1 2 3 4 5 6 7 8 9 10
No Academic Some Academic Severe Academic
Interference Interference Interference

1 2 3 4 5 6 7 8 9 10
No Social Some Social Severe Social
Interference Interference Interference

What would you like to achieve in meeting with a counselor today?
