Confidential: Center for Counseling and Psychological Health
University of Massachusetts
Amherst, MA 01003
413–545-2337

LABEL

Last Name: _____ MRN #_____
First Name: _____ MI: _____
DOB: _____ Sex: _____
Date of Service: _____ Visit # _____
Provider: _____

Basic information:

Local address: _____ Permanent address: _____

_____ _____

Phone: _____ _____

Cell Phone: _____ Phone: _____

Emergency contact: _____ Emergency contact phone: _____

Optional information: Ethnicity _____ Religion: _____

Employment information:

Hours worked per week: _____ Place of employment: _____

Phone: _____

Status:

☐ Student ☐ Student family ☐ Post-doc ☐ Hampshire College

☐ UMass employee ☐ UMass employee family ☐ Other *(please explain)*: _____

Students only:

Academic status: ☐ First-year ☐ Sophomore ☐ Junior ☐ Senior ☐ Graduate ☐ Continuing Ed.

☐ Other (please explain): _____ Are you a transfer student? ☐ Yes ☐ No

Major: _____ Expected graduation date: _____

Insurance: *(Check all that apply)*

☐ Student Health Fee ☐ Student Health Insurance ☐ Health New England ☐ Navigator by Tufts ☐ Harvard Pilgrim

☐ Commonwealth Indemnity (Unicare) ☐ Blue Cross ☐ Other *(please specify)*: _____

Clinical information:

Please describe briefly the problems troubling you now and what kind of help you are specifically requesting:

_____

_____

_____

_____

_____

_____

_____

_____

TURN OVER, PLEASE

Referral source: (*Who was most influential in your decision to come here?*) ☐ BASICS ☐ Athletic coach
☐ CMASS ☐ Dean of Students ☐ Stonewall ☐ Faculty/academic advisor ☐ Res. Life
☐ Self ☐ UHS physician/nurse *(name)*: _____ ☐ Other *(specify)*: _____
_____

Counseling/therapy history:
Have you had previous counseling/therapy experience? ☐ Yes ☐ No Psychiatric hospitalization? ☐ Yes ☐ No
If yes, please indicate approximately when: _____ Therapist's name: _____

Medical history:
Have you ever had any serious illnesses, injuries, or surgery? *(Please specify)*:
_____
Please list all current prescription and over-the-counter medications, and any past or present prescriptions for emotional symptoms: _____

Relationship status: *(Check all that apply)*
☐ Single ☐ In a relationship ☐ Living with partner ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Do you have any children? ☐ Yes ☐ No Age _____ _____ _____ _____ _____ _____ _____ _____
Sex _____ _____ _____ _____ _____ _____ _____ _____

Family history:
Are your parents living together? ☐ Yes ☐ No
Are any members of your immediate family deceased? ☐ Yes ☐ No If yes, specify person(s): _____
_____, age(s) _____ and date(s): _____

Parents:	Age: _____	Occupation: _____	Age: _____	Occupation: _____
	Age: _____	Occupation: _____	Age: _____	Occupation: _____
Brothers:	Age: _____	Occupation: _____	Age: _____	Occupation: _____
	Age: _____	Occupation: _____	Age: _____	Occupation: _____
Sisters:	Age: _____	Occupation: _____	Age: _____	Occupation: _____
	Age: _____	Occupation: _____	Age: _____	Occupation: _____

Current situation:
Are you currently having academic problems? ☐ Yes ☐ No
Are you currently having any work problems? ☐ Yes ☐ No
Have you ever had an unwanted sexual experience? ☐ Yes ☐ No
Do you have concerns about your eating behaviors? ☐ Yes ☐ No and/or weight? ☐ Yes ☐ No
Do you believe your current concern is related directly or indirectly to drug and/or alcohol use?
(Check all that apply): ☐ Yes, my own drug and/or alcohol use
☐ Yes, the use of drugs and/or alcohol by people around me
☐ No
If necessary, may we leave a message: On your voicemail/answering machine? ☐ Yes ☐ No
With another person? ☐ Yes ☐ No

"I have read the attached statement of confidentiality and understand that if I have any questions, I will discuss them with the staff person who conducts the assessment."

Signature: _____