Wellness Center
Appointment Request & Intake Form

Date: _______________________

Student Information
First Name__________________________________________ MI________ Last Name__________________________________________
Birth Date_______________________________________ Banner ID Number________________________
Address________________________________________ City________ State_______ Zip Code________________________
Email Address_______________________________________ Cell Phone________________________________

Insurance (To be used if making a referral)______________________________________________________________

Emergency Contact Information
Name__________________________________________ Relationship________________________________________
Phone__________________________________________ May we contact this person if you are in crisis? □ YES □ NO

Questionnaire
1. Prior counseling or therapy: □ YES □ NO

2. Reasons for visit:
☐ I am currently so upset that I may be unable to keep myself or others safe.
☐ I have a current plan to attempt suicide or to harm someone else.
☐ I have been physically or sexually assaulted within the last few days.
☐ Someone close to me has died within the last few days.
☐ I am having strange experiences such as hearing voices or seeing things that others do not.
☐ I have knowledge of another person being abused or assaulted.
☐ I have witnessed a traumatic event within the last few days.
☐ Other:__________________________________________________________________________________________

3. Current supports:
☐ Community ☐ Spiritual
☐ Family ☐ Significant other
☐ Friend(s) ☐ Other:_____________________________________________________

4. Student reports symptoms of (in last month)
☐ Alcohol/Drugs ☐ Loneliness/Homesickness ☐ Sexual Concerns
☐ Body Image ☐ Loss of Significant Person ☐ Sexual Misconduct
☐ Depression ☐ Parental Alcohol/Drug Use ☐ Sleeping Problems
☐ Disability ☐ Physical Stress/Headaches ☐ Speech Anxiety
☐ Domestic Violence ☐ Mental/ Emotional Stress ☐ Procrastination
☐ Self Esteem/Confidence ☐ Romantic Relationship Issues ☐ Suicidal Ideation
☐ LGBTQI Concerns ☐ Family/Friend Relationship Issues ☐ Test Anxiety

Wellness Center N114 • 203-285-2480 • http://www.gatewayct.edu/wellnesscenter
October 2018/KA
Inadequate Academic Preparation

Other: __________________________

5. To what degree do you feel like your academic progress is being impacted by your issue?
☐ Not at all     ☐ Barely     ☐ Somewhat     ☐ Mostly     ☐ A lot

6. Medications
☐ I am currently taking prescribed psychiatric medication.
☐ I have taken prescribed psychiatric medication in the past.
☐ I have stopped taking prescribed psychiatric medication.
☐ I have never taken prescribed psychiatric medication.

7. Would you prefer a Spanish speaking counselor?  ☐ YES  ☐ NO

Appointment Policy
If you need to cancel your appointment, please let us know by calling 203-285-2480. Kindly give us a 24-hour notice if possible.

Emergency Situations
- For on-campus emergencies — please come to the Wellness Center or call Campus Security at 203-285-2246.
- For off-campus emergencies — call 911 or go to your nearest Emergency Room.

Confidentiality
Any discussion and information you share with a counselor will remain confidential. This means that without your prior written consent, information will not be divulged to anyone except in the following special circumstances, which are required by law:
- If you are in immediate danger of harming yourself or someone else;
- If you disclosed that a child, disabled, or elderly person is being abused;
- If a court of law orders such information to be divulged (subpoena);
- For the purpose of consultation or supervision of your case with a professional colleague or clinical supervisor.

To be completed by counselor only:

Goals for student’s meeting:
________________________________________________________________________
________________________________________________________________________

Additional Notes:
________________________________________________________________________
________________________________________________________________________

Action:  ☐ Make Referral  ☐ Schedule Follow-Up Appointment
Counselor Signature_________________________________________________________ Date__________________