FAIRLEIGH DICKINSON UNIVERSITY
Student Wellness Services

Office of Mental and Emotional Wellbeing
Metropolitan Campus
1000 River Road
Teaneck, NJ 07666
201 692-2174

STUDENT INTAKE ASSESSMENT FORM

First Name:_____ Middle:_____ Last: _____ Date: _____

Preferred Name:_____ Date of Birth:___/___/___ Age: _____

Student ID: _____ Gender: ☐ Female ☐ Male ☐ Transgender ☐ Other (Identify): _____

Cell: _____

Email: _____

Home Address: _____

Can we contact you at the above number/email? ☐ Yes ☐ No

Student Information

Sexual Orientation: ☐ Heterosexual ☐ Bisexual ☐ Gay ☐ Lesbian ☐ Asexual ☐ Questioning ☐ Prefer not to say

Preferred Pronouns:_____ Relationship Status:_____ Ethnicity:_____

Living Situation: ☐ Alone ☐ Roomate(s) ☐ Partner/Spouse ☐ Parent(s) ☐ Commuter

☐ Off Campus ☐ On Campus (location and room: _____)

Do you have a disability? ☐ No ☐ Yes (Explain): _____

International student: ☐ No ☐ Yes (Country) _____

Academic Information

Major: _____

Year: _____

Current Credit Load: _____

Regularly attending classes? ☐ Yes ☐ No

List any clubs, organizations, college sports, extra curriculars you are involved in:

_____

_____

_____

Transfer Student? ☐ Yes ☐ No

First in your family to attend college? ☐ Yes ☐ No

Veteran: ☐ No ☐ Yes (branch) _____

Dates of Service_____

Employment Information

Currently employed? ☐ Yes ☐ No

Type of work: _____

Hours/week: _____

Regularly attending work? ☐ Yes ☐ No

☐ On-Campus ☐ Off-Campus

If off-campus, list where: _____

Emergency Contact Information

Name: _____

Cell Number: _____

Home Number: _____

Email: _____

Relationship to student (you): _____

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Health History

Please provide any history of outpatient psychiatric care:
Psychiatrist/Counselor name: _____
Duration (start and end date): _____
Reason for discontinuation, if any? _____
Other important information: _____
_____

Have you ever had a head injury? ☐ **No** ☐ **Yes (Explain):** _____

Have you ever been hospitalized for psychiatric attention? ☐ **Yes** ☐ **No**

- **If yes, please specify reasons for hospitalization:**
  - ☐ **Psychological problems**
  - ☐ **Suicide ideation/plan/attempt**
  - ☐ **Danger to self or others**
  - ☐ **Substance misuse**
  - ☐ **Other:** _____
- **If yes, provide details:** _____
- **Dates:** _____

Please provide other medical history: _____
_____

Have you ever experienced any significant personal/emotional difficulties (verbal, emotional, psychological, physical, sexual, etc.) before now? If so, please provide details
_____
_____
_____

Does any member of your immediate or extended family suffer from an emotional or mental difficulty? If so, what kind of difficulty? Did they receive treatment?
_____
_____
_____

How would you describe your childhood?
_____
_____
_____

Any previous or current forms of self-help?
_____
_____

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Current Situation

Please list up to three problems or reasons you had for coming to counseling today. Then rate how upsetting each problem is to you, and how long it has been troubling you.

Problem	How upsetting?	How long?
_____	(mild) 1___3____5 (severe)	_____
_____	1_____3_____5	_____
_____	1_____3_____5	_____

What made you decide to call for an appointment?

_____

_____

Who were you referred by? _____

Do you currently take any medications? ☐ Yes ☐ No

Medication	Dose	Date	Prescriber
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list the members of your immediate family, their relationship to you, and their ages.

Family Member	Relationship	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____

Who are the most significant people in your life that you consider your social support? What is their relationship to you?

_____

_____

_____

Religious preference: _____

Any cultural/religious relevance to your concerns? _____

_____

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Current Situation Continued:

Check all that apply for you:

- ☐ Disorganized
- ☐ Distracted
- ☐ Detached/Numb
- ☐ Unmotivated
- ☐ Impulsive
- ☐ Jumpiness
- ☐ Reckless
- ☐ Poor Concentration
- ☐ Procrastination
- ☐ Skipping Classes

- ☐ Violent fantasies or thoughts
- ☐ Physical aggressive to self or others
- ☐ Anger management problems
- ☐ Isolation/Withdrawing
- ☐ Experienced abuse and/or trauma
- ☐ Hallucinations
- ☐ Nightmares
- ☐ Flashbacks
- ☐ Paranoia
- ☐ Obsessive thoughts
- ☐ Compulsive behaviors/rituals

Sleeping Habits
- ☐ oversleeping
- ☐ under-sleeping

Nutrition Habits
- ☐ overeating
- ☐ under-eating
- ☐ over-exercising
- ☐ nausea/vomiting

Substance Use

Do you drink alcohol? ☐ Yes ☐ No

If yes:

- Drink of preference? _____
- How frequently do you drink alcohol? _____
- How much alcohol do you consume per week? _____

Do you engage in drug use? ☐ Yes ☐ No

If yes:

- Drug preference? _____
- How frequently do you consume drugs? _____
- Method of consumption: _____
- What is the quantity of drugs consumed per week? _____

Do you smoke/vape? Yes no

If yes, frequency: _____

Do you consider your substance use an issue? ☐ Yes ☐ No

- If yes, explain: _____

History of rehab/detox admission: _____

Office Notes:

BAI Score _____ *BDI-II Score* _____