



## PART 3: DEMOGRAPHIC INFORMATION

### 1. What is your gender identity?

- Female
- Male
- Female to male transgender (FTM)
- Male to female transgender (MTF)
- Agender
- Other (please specify): \_\_\_\_\_
- Prefer not to answer

### 2. What is your race?

- Hispanic or Latino
- Black or African American
- White
- Native American or American Indian
- Asian/Pacific Islander
- Other (please specify): \_\_\_\_\_
- Prefer not to answer

### 3. What is the highest degree or level of school you have completed?

- Some High School/GED
- High School Diploma/GED
- Some Undergraduate Coursework
- 2-Year College Degree (Associates)
- 4-Year College Degree (BA, BS)
- Some Graduate Coursework
- Graduate Degree (e.g. MA, MFA, PhD, MD)
- Other (please specify): \_\_\_\_\_

### 4. What is your current marital status?

- Single/Never Married
- Married
- Separated
- Divorced
- Widowed
- Prefer not to answer

### 5. What is your current employment/ volunteer status?

- Employed Full-time (40+ hours per week)
- Employed Part-time (1-39 hours per week)
- Volunteer Full-time (25+ hours a week)
- Volunteer Part-time (1-20 hours a week)
- Unemployed

### 6. What is your current religious affiliation?

- Christianity
- Judaism
- Buddhism
- Islam
- Hinduism
- Agnosticism
- Unaffiliated
- Other (please specify): \_\_\_\_\_
- Prefer not to answer

### 7. Military Status:

- No, Military Service
- National Guard
- Armed Forces
- Other (please specify): \_\_\_\_\_

### 8. Citizenship Status

- U.S Citizen
- Non-resident Allen-Visa type \_\_\_\_\_ Exp. Date: \_\_\_\_\_
- Permanent Resident

### 9. What is your sexual identity?

- Heterosexual, or straight
- Homosexual – gay or lesbian
- Bisexual
- Other (please specify): \_\_\_\_\_
- Prefer not to answer
- Asexual

## PART 4: EDUCATION

1. Name of High School: \_\_\_\_\_
2. What is your current enrollment status in college? (e.g. enrolled, medical leave) \_\_\_\_\_
3. Name of college you most recently attended/ currently attend: \_\_\_\_\_
4. Names of other colleges you have attended:  
\_\_\_\_\_
5. What was the last semester you were enrolled in classes? \_\_\_\_\_
6. How many classes/credits did you attempt in your last semester? \_\_\_\_\_
7. How many classes/credits did you complete during that semester? \_\_\_\_\_
8. If you are on a leave, for what reasons are you taking time away?  
\_\_\_\_\_  
\_\_\_\_\_
9. What is your major/area of study? \_\_\_\_\_
10. Check the programs/assistance/services you used at your college/university:

<input type="checkbox"/> Individual counseling	<input type="checkbox"/> Support from the writing studio
<input type="checkbox"/> Group counseling	<input type="checkbox"/> Accommodations through the disability services office
<input type="checkbox"/> Drug/alcohol education/support programing	<input type="checkbox"/> Academic/life coaching
<input type="checkbox"/> Campus housing	<input type="checkbox"/> Academic advising
<input type="checkbox"/> Tutoring in content areas (e.g. engineering)	<input type="checkbox"/> Financial aid/scholarships
11. If you received academic/life coaching, with whom did you meet and how regularly?  
\_\_\_\_\_
12. If you used accommodations through disability services, what were they?  
\_\_\_\_\_
13. What would you identify as your strengths in the classroom?  
\_\_\_\_\_
14. What are some barriers you may have experienced in the classroom?  
\_\_\_\_\_

## PART 5: SKILLS ASSESSMENT

Below are lists of tasks and skills important for social, emotional, and academic wellness. Check the box that best describes your strengths and challenges in various settings.

### 1. Social & Interpersonal Wellness

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
<i>Being a member of a group is important to me</i>					
<i>I tend to engage in discussions when I'm with others</i>					
<i>I feel a part of the school community</i>					
<i>I connect easily with my same-age peers</i>					
<i>I am satisfied with my social life</i>					
<i>I know when to advocate for help</i>					
<i>I feel comfortable explaining my health leave to friends</i>					

### 2. Physical Wellness

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
<i>I keep a regular sleep routine</i>					
<i>I maintain a healthy diet</i>					
<i>I keep a daily hygiene schedule</i>					
<i>I take my medication as prescribed</i>					
<i>I access medical care when needed</i>					
<i>I exercise regularly</i>					
<i>I take breaks during the working day/while studying</i>					
<i>I am can predict when my symptoms will increase</i>					

### 3. Communication Skills

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
<i>I speak in an appropriate volume</i>					
<i>I find others are able to comprehend what I say/do</i>					
<i>I am comfortable advocating for help</i>					
<i>I am respectful while others speak</i>					
<i>It is easy for me to understand what others say/do</i>					
<i>I tend to talk too much</i>					
<i>I feel comfortable engaging in small talk</i>					

**4. Behavior**

	<b>Strongly Disagree</b>	<b>Disagree</b>	<b>Undecided</b>	<b>Agree</b>	<b>Strongly Agree</b>
<i>I mostly think prior to acting</i>					
<i>I am able to follow through on responsibilities</i>					
<i>I am able to accept responsibility for my mistakes</i>					
<i>Sometimes my behavior seems strange to others</i>					
<i>I often "lose time"</i>					
<i>I have healthy coping strategies to manage stress</i>					
<i>I have abused substances</i>					

**5. Medication**

	<b>Strongly Disagree</b>	<b>Disagree</b>	<b>Undecided</b>	<b>Agree</b>	<b>Strongly Agree</b>
<i>My medication(s) make(s) me drowsy</i>					
<i>My medication(s) blur(s) my vision</i>					
<i>I am often thirsty</i>					
<i>My medication(s) effect(s) my thinking</i>					
<i>I feel comfortable being on medication(s)</i>					

**6. Thinking/Learning**

	<b>Strongly Disagree</b>	<b>Disagree</b>	<b>Undecided</b>	<b>Agree</b>	<b>Strongly Agree</b>
<i>I am able to concentrate for long periods of time</i>					
<i>I am easily distracted</i>					
<i>I am able to quickly learn and retrieve new information</i>					
<i>I shift my attention between tasks easily</i>					
<i>I can easily make decisions</i>					
<i>I am organized</i>					
<i>I usually have the energy to do my work</i>					
<i>I excel at working on tight deadlines</i>					
<i>I am flexible with unexpected changes</i>					
<i>I feel comfortable getting called on in class</i>					

**7. Emotional Wellbeing**

	<b>Strongly Disagree</b>	<b>Disagree</b>	<b>Undecided</b>	<b>Agree</b>	<b>Strongly Agree</b>
<i>I manage my worries well</i>					
<i>I remove myself from uncomfortable situations</i>					
<i>I am comfortable when others express strong feelings</i>					
<i>My reactions often match others'</i>					
<i>I am comfortable telling others how I feel</i>					
<i>I accept as much responsibility as I can handle</i>					
<i>I monitor my symptoms well</i>					
<i>I include my treatment team when making decisions about school or work</i>					
<i>I communicate with my spiritual advisor/rabbi/priest/other regularly</i>					
<i>My treatment team is helpful</i>					

**8. Resource Needs**

	<b>Strongly Disagree</b>	<b>Disagree</b>	<b>Undecided</b>	<b>Agree</b>	<b>Strongly Agree</b>
<i>I have a secure income to cover the cost of transportation to/from the Center</i>					
<i>I have a secure income to pay for meals</i>					
<i>One of my goals is to find a/a new health care provider</i>					
<i>I have a place where I can effectively study/work</i>					
<i>My housing situation is stable</i>					
<i>One of my goals is to find housing/new housing</i>					
<i>One of my goals is to connect with a provider/disability services at my school</i>					

## PART 6: GOALS & INTERESTS

1. List your top 3 academic priorities (e.g. transfer to a new college, finish/submit incomplete work)?

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2. What are your career goals or interests (e.g. thinking about studying philosophy)?

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3. What are your personal/life goals (e.g. join a band, start dating)?

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4. What skills do you want to work on in our college wellness programs (e.g. make friends, practice test-taking)?

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5. . What interests you about joining the College Mental Health Programs?

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6. What worries you about joining the College Mental Health Programs?

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7. Please identify your interests in the following domains: What are your favorite activities, pastimes, hobbies?

Physical:

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Social:

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Leisure:

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Spirituality:

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### PART 7: PARENT/GUARDIAN INFORMATION

#### Parent/Guardian 1

Name:

Relationship to Student:

Address:

Phone (Primary):

Phone (Secondary):

Email:

#### Parent/Guardian 2

Name:

Relationship to Student:

Address:

Phone (Primary):

Phone (Secondary):

Email:



## PART 8: EMERGENCY CONTACT

Name:	
Relationship to Student:	
Address:	
Phone (Primary):	Phone (Secondary):
Email:	

## PART 9: PROFESSIONAL SUPPORTS

### Primary Care Physician

Name:	
Medical Facility/Clinic/Program:	
Address:	
Phone (Primary):	
Phone (Secondary):	
Email:	

### Psychiatrist

Name:	
Medical Facility/Clinic/Program:	
Address:	
Phone (Primary):	
Phone (Secondary):	
Email:	

### Therapist or Counselor

Name (Primary contact):	
Counseling Service:	
Address:	
Phone (Primary):	
Phone (Secondary):	
Email:	

<b>College/University Behavioral Health</b>
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Name (Primary contact):
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Counseling Service:
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Address:
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Phone (Primary):
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Phone (Secondary):
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Email:
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<b>Vocational or Employment Coach</b>
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Name (Primary contact):
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Counseling Service:
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Address:
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Phone (Primary):
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Phone (Secondary):
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Email:
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Stephanie Cummings, Recovery Center Manager  
Recovery Services Division  
940 Commonwealth Avenue West  
Boston, Massachusetts 02215  
T 617-353-1124 F 617-353-7700  
[stephc13@bu.edu](mailto:stephc13@bu.edu)  
[cpr.bu.edu](http://cpr.bu.edu)

***Please complete this form, and fax it to Stephanie Cummings at (617) 353-7700.***

*If you have questions about the application process or College Mental Health Programs at the Center for Psychiatric Rehabilitation, please contact Courtney Joly-Lowdermilk at (617) 483-3827 or [cjoly@bu.edu](mailto:cjoly@bu.edu).*

## MEDICAL AND PSYCHIATRIC FORM

**Patient's Full Name:** \_\_\_\_\_

**Physician/Psychiatrist Full Name:** \_\_\_\_\_

**Medical Facility/Clinic/Program:** \_\_\_\_\_

**Date of Last Examination/Assessment:** \_\_\_\_\_

**Diagnoses:** \_\_\_\_\_

**Full DSM or ICD-10 Code(s):** \_\_\_\_\_

**Initial date of diagnosis:** \_\_\_\_\_

**Date of Last Clinical Contact:** \_\_\_\_\_

Psychiatric or Other Medication(s)

**Physician/Psychiatrist's Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_