Instructions:

1. Print the form.

2. Complete it, and bring it with you when you make your appointment.

3. Please do not email or fax the form since these are both non-secure methods of transmission. Therefore, we cannot guarantee your confidentiality.

4. If you have any questions, please call us at 395-2207.
INFORMED CONSENT

The Counseling Center and the Health Center together make up what is referred to as Student Health Services. We realize that you may have concerns about providing highly personal information. All records at Student Health Services are confidential. Information may be released to appropriate individuals or agencies only upon your written request. CONFIDENTIALITY will be maintained except under the following conditions and with the following limits:

1) If needed, we will seek supervision and consultation from professional colleagues within Student Health Services to aid us in our work with you. These colleagues also must treat your information as confidential, within the same legal limits.

2) If we believe you pose a life-threatening risk to yourself or others, we may need to notify responsible individuals for your protection and/or the protection of others.

3) If you are under the age of 18 and a victim of child abuse, we are required by law to file a report with Child Protective Services.

4) If records are subpoenaed directly by a court, we are required by law to release records and perhaps be called to testify at those proceedings.

5) If you reveal to us that you are abusing your, or any, minor child we are required by law to file a report with Child Protective Services.

6) If you are referred to our psychiatric consultant, a copy of our evaluation may be placed in your Health Center file, and we may consult with Health Center Staff.

If circumstances necessitate the release of information outside Student Health Services as outlined above, you will be notified as soon as reasonably possible. In all other situations, information may be released to appropriate individuals or agencies only upon your written request. If you have any questions regarding the above conditions, please discuss them with your intake counselor.

I have read and understand the statements regarding Informed Consent

____________________________________________  __________________
Signature         Date
Please provide the following information

Please complete this questionnaire so that we may obtain a more comprehensive picture of your current concerns and background. Please answer the questions as honestly and accurately as you possibly can. Your answers will help us determine the best way we can serve you.

DATE_____/_____/_____

BANNER ID #_____ - _____ - _____

NAME: ____________________________________________________________

Last     First     MI

Local Address: ______________________________________________________

Street     City     Zip Code

Permanent Address: _________________________________________________

Street

Local Phone number: ___________________________ / ___________________________

Home (Leave message? Yes____ No____)  Cell (Leave message? Yes____ No____)

Birth date: _____/_____/_____

Age_____  Ethnicity__________

Class: FR   SO   JR   SR   Grad   Non-matric   Status: FT/PT

Major: ____________________________

GPA: ____________________________

Who suggested you come to the Counseling Center? ______________________________________

Have you ever had counseling before? If so, when/where? __________________________________

**What brings you to the Counseling Center today? ______________________________________

____________________________________

____________________________________

Below is a list of issues that sometimes cause concern. Please indicate those that currently apply to you:

**Academic/Career Concerns**

___Grades

___Learning disability

___Study skills

___ADD/ADHD

___Uncertainty about major/goals

___Performance/test anxiety

___Difficulty concentrating/focusing on work

**Interpersonal Concerns**

___Relationship with friends/roommate

___Relationship with significant other

___Adjusting to being at college/away from family

___Social anxiety concerns

___Relationship with parents/family

___Difficulty making friends

___Difficulty being assertive

**Depression**

___Suicidal thoughts/gestures

___Overeating

___Under eating

___Feeling hopeless

___Feeling worthless/guilty

___Decreased interest in activities

___Extreme mood swings

___Irritability/anger issues

___Sleep problems

___Sad mood

___Crying for “no reason”

___Lack of energy/motivation

___Fatigue/feeling tired all the time

**Anxiety**

___Fearful for no apparent reason

___Heart palpitations

___Dizziness

___Fear of losing control or “going crazy”

___Excessive worry

___Shortness of breath

___Shakiness

___Hot flashes

___Obsessive thoughts/images/worries

___Repetitive behaviors or mental acts
Trauma:
___History of sexual abuse    ___History of emotional/verbal abuse
___History of physical abuse    ___History of violence in relationships
___Date rape    ___Unwanted sexual contact
___Victim of violence    ___Other trauma: ________________________________

Eating Concerns:
___Binge eating    ___Purging after eating
___Restricting food intake    ___Body image
___Preoccupation with food/dieting    ___Excessive exercising (more than 4 times a week)

Legal:
___Campus Judicial/Student Conduct referral
___Court or other legal mandate

Miscellaneous:
___Ethnic/racial concerns    ___Sexual identity/orientation/gender concerns
___Financial problems    ___Sexual concerns
___STD concerns    ___Medical problem/concerns
___Pregnancy    ___Mental illness in family
___Difficulty controlling anger/impulses    ___Grief/loss issues

Medical History:
Are you taking any prescribed medications? _______ If so, please specify:
________________________________________________________________________________________________

Who is your primary health care provider?_____________________________ Do you utilize the Health Center?_______

Do you have any medical problems or concerns? _______ If so, please specify:
________________________________________________________________________

Please indicate if you have any of the following concerns and immediately advise your counselor:

- Current thoughts of suicide    Yes ___ No ___
- Previous attempts at suicide    Yes ___ Date of attempt_________ No___
- Prior psychiatric hospitalizations    Yes ___ Date of hospitalization_________ No____
- Current self-injurious behavior (e.g. cutting self)    Yes ___ No ___
- Current thoughts of harming someone else    Yes ___ No ___
- Current hallucinations/hearing voices    Yes ___ No ___

Alcohol/Drug
___Concerned about own use
___Concerned about another's use
___Alcoholism in my family

Alcohol/Drug Assessment:

<table>
<thead>
<tr>
<th>Drug/Last Use</th>
<th>Age of First Use</th>
<th>How often are you currently using?</th>
<th>Date of Last Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>_____</td>
<td>Never Daily Weekly Monthly</td>
<td>_____</td>
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<tr>
<td>Marijuana</td>
<td>_____</td>
<td>Never Daily Weekly Monthly</td>
<td>_____</td>
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<tr>
<td>Cocaine</td>
<td>_____</td>
<td>Never Daily Weekly Monthly</td>
<td>_____</td>
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<tr>
<td>PCP</td>
<td>_____</td>
<td>Never Daily Weekly Monthly</td>
<td>_____</td>
</tr>
<tr>
<td>Ecstasy</td>
<td>_____</td>
<td>Never Daily Weekly Monthly</td>
<td>_____</td>
</tr>
<tr>
<td>Other</td>
<td>_____</td>
<td>Never Daily Weekly Monthly</td>
<td>_____</td>
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</tbody>
</table>

OVER
Family Information: Please indicate information about your immediate family

<table>
<thead>
<tr>
<th>Name/Relationship</th>
<th>Age</th>
<th>Occupation/School</th>
<th>Medical/Mental Health/Substance Abuse History</th>
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<tbody>
<tr>
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</table>

Genogram (counselor will create and review with you)

Please take a moment to tell us any other concerns you may have or issues you would like to discuss with your counselor. Thank you.

______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
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______________________________________________________________________________________