Southwestern University Counseling Services

The following information is needed to best help you. Please clearly print your response to each question. This will help save time in your first session. If you are unable to complete some parts, then leave them blank and you will have a chance to complete them with your counselor. Case records are strictly confidential.

SECTION I: IDENTIFYING INFORMATION

Today's Date: _____

Name _____ Hometown _____

Date of Birth _____ Age ___ Sex: _____ Racial /ethnic background _____

Local address _____ City/State _____ Zip _____

Phone (C/H) _____ E-mail _____ Best way to reach you / private for messages _____

Emergency contact _____ Relationship _____ Phone _____

Veteran or dependant of veteran? Y/N _____

While here at SU, with whom do you live?

Name	Age	Relationship to you	Supportive? Y / N

SU Classification: ☐ First-year ☐ Sophomore ☐ Junior ☐ Senior – graduating when? _____

Major/minor _____ Cumulative SU GPA _____

How many hours are you taking this semester? _____ How many hours per week are you employed? _____

SECTION II: DESCRIPTION OF PRESENTING PROBLEM

Please state why you decided to come to Counseling Services:

_____

_____

_____

_____

Please tell us what you want to work on or change in counseling:

_____

_____

_____

_____

How long has this been a significant problem for you? *Please be specific (i.e., not "all my life").*

_____

_____

Have you ever been given a mental health diagnosis in the past from a mental health professional? Yes _____ No _____

If yes, as you understand it, what is/was that diagnosis? _____

SECTION II: DESCRIPTION OF PRESENTING PROBLEM (CONT.)

What symptoms contributed to you coming in today? (Please check all that apply)
blank = no concern ✓ = some concern ✓✓ = moderate concern ✓✓✓ = significant concern

__overeating	__restless	__rapid heart rate	__compulsive behaviors
__taking drugs	__depressed mood	__sweating	__impulsive behaviors
__odd behavior/thoughts	__crying	__trembling or shaking	__fears/phobias
__recent weight gain	__difficulty concentrating	__shortness of breath	__anxiety
__recent weight loss	__low motivation	__muscle tension	__vomiting
__recent appetite changes	__aggressive behavior	__outbursts of temper	__distrust
__social withdrawal	__feelings of worthlessness	__nightmares	__jumpy
__family emotional problems	__stomach problems	__easily distracted	__dizzy or lightheaded
__chest pain	__sleeping too much	__decreased need for sleep	__fatigue/loss of energy
__difficulty falling asleep	__problems with school	__housing problems	__obsessions
__difficulty staying asleep	__pain	__drinking alcohol	__relationship problems
__experienced a traumatic event	__financial problems	__can't turn my mind off	__other: _____

If applicable, please describe any incidents or problems that may have contributed to this problem (e.g., problem with academic program, relationship ending, past trauma, etc.):

_____

_____

In the past, what has been helpful to you in dealing with this problem? _____

_____

SECTION III: MEDICAL HISTORY

Name and location of Physician _____ Date of your last physical exam: _____

Please list any significant past or current **health, medical, or psychiatric issues** (including anything resulting in hospitalizations).

Dates	Problem & Treatment	Were you hospitalized (Y/N)

Have you ever experienced: (Please mark all that apply)
Emotional abuse _____ Physical abuse _____ Sexual abuse _____ Sexual assault _____

Have you **ever had treatment by**, or are you **currently seeing**, a psychiatrist, psychologist, therapist, or counselor? Yes ____ No ___

Problem	Where	Therapist	When?	Helpful? (Y/N)

SECTION IV: MEDICATIONS AND SUBSTANCES USED

If applicable, please list all medications you are now taking or have taken in the past three months, **including birth control pills, vitamins, herbs and supplements**.

Medication	Dosage	Person prescribing	How long have you been taking this?	Helpful (Y/N)

If applicable, amount of **caffeinated** beverages per day: coffee _____ soda ___ espresso _____ tea ____ other (specify) _____

If applicable, number of cigarettes smoked per day: _____ If applicable, how often do you use marijuana per week? _____

SECTION IV: MEDICATIONS AND SUBSTANCES USED (CONT.)

Consider a typical week during the **past month**. Please fill in a number for each day of the week indicating the typical number of drinks you usually consume on that day and the typical number of hours you usually drink on that day.

1 Drink = 12 oz. beer / 10 oz. microbrew / 8 oz. malt liquor
4 oz. of wine
1 oz. of hard alcohol (regular shot glass)

	Su	M	T	W	Th	F	Sa
Number of drinks							
Number of hours							

Think of the occasion that you drank the most in the **past month**.
How much did you drink? _____ How many hours did you drink? _____
If applicable, other substances used _____

Do you use alcohol or drugs to (check all that apply):
Manage stress? _____ To relax? _____ To change mood? _____ For sleep? _____

How often do you gamble, including internet pay sites? (please mark one response)
☐ Never ☐ Once a Year ☐ 2 to 3 Times a Year ☐ Every Other Month ☐ Once a Month ☐ 2 to 3 Times a Month
☐ Weekly ☐ More Than Once a Week ☐ Every Other Day ☐ Every Day

Consider a typical week during the **past month**. How much time did you spend playing video games or surfing the internet for **non academic reasons**? _____

SECTION V: FAMILY OF ORIGIN AND RELATIONSHIP INFORMATION

	Name	Age	Occupation	Deceased (Y/N)
Parent/Guardian				
Parent/Guardian				
If applicable:				
Stepparent				
Stepparent				
Siblings				

If applicable:			Living with you? (Y/N/Part time)	
Children				

Are your parents divorced? Yes ___ No ___ If Yes, when did they divorce? _____

Have any members of your family had problems with:
drugs ___ alcohol ___ depression ___ anxiety ___ other mental illness ___ diabetes ___ epilepsy ___

Problem	Who	Current Y / N	Past Y / N

Among your friends and family, whom do you count on for support? _____
_____

Are you: Single _____ Dating _____ Married/Partnered _____ Recently broken up _____ If so, when? _____

If applicable, describe your relationship with your current partner. _____
_____

How long have you been in the relationship? _____
Is there anything else we need to know to assist you? Please ask for an extra sheet of paper if needed.

Southwestern University Counseling Services
Client Rights and Responsibilities

SU Counseling Services provides free, confidential, short-term counseling to SU students. You and your counselor will determine the number of sessions and the type of counseling (individual, relationship, or group) appropriate for you. Individual counseling sessions last approximately *50 minutes*. If you are interested in long-term counseling or would like to see someone other than a psychologist, we can help you identify licensed professionals off campus. If you require special accommodations due to a disability, please let your counselor know.

Client Rights

Texas law provides that, if you are 18 years of age or older, information about your counseling may not be released from Counseling Services without your written permission **EXCEPT** *in the following circumstances*: 1) if you are a danger to yourself or someone else and protection from harm is required; 2) if your counselor receives information that a child, a disabled person, or an elderly person has been abused or neglected; 3) if your counselor receives information that a therapist has sexually exploited a client (in this case, the therapist must be reported but your anonymity can be preserved); or 4) if your counselor is ordered by a judge to release particular information in a legal proceeding (this is rare, but can occur, for example, in divorce/custody cases or personal injury cases).

No record of your counseling is made on academic records or job placement files. Some graduate schools, future employers (e.g., the military), or licensing bodies (e.g., the State Bar Association) may ask you to release information about past counseling, but this is solely at your discretion.

You have the right to inquire about the professional credentials and experience of your counselor, to refuse a particular recommendation, to discuss concerns and dissatisfactions about your counseling with your counselor, and to end counseling at any time.

Client Responsibilities

The most important client responsibility is participation. Taking an active role in counseling involves being open and honest with your counselor, completing outside tasks when asked, and providing feedback to your counselor about how your counseling is going. *Please arrive on time for appointments. Please notify the office at least 24 hours ahead of time if you cannot keep your appointment.*

<u>The more energy you put into counseling, the more benefits you will receive.</u>

Audio and video recording

- SU Counseling Services wishes to provide the best service possible to students; thus, we are continually working to enhance our own skills as therapists. Your therapist may request your permission to audio- or videotape sessions with you. Counseling Services and your therapist assure you that these tapes will be used only for quality assurance. The tapes will not be reviewed by anyone outside of this agency.
- Tapes will be erased after being reviewed. If you do not want your sessions to be taped, you are under no obligation to consent to this request.

___ Yes, Counseling Services may audio- or videotape my sessions

___ No, Counseling Services may not audio- or videotape my sessions

Supervised Clinical Staff

- Some services at SU's Counseling services are provided by Pre-Doctoral Counseling/Clinical
Psychology Practicum Counselors or professionals not yet licensed.
- You will be informed if your therapist is in one of these categories and who is supervising that therapist.
- You may request not to receive services from a person in one of these categories.

Other Important Information

Because Counseling Services takes a biopsychosocial approach to counseling we work very closely and collaboratively with The SU Health Services. Frequently it is useful for our professional staff to consult with each other to provide you with the most comprehensive care. Please check below your choice about allowing Counseling and Health Services staff to consult about your care.

____ Yes, Counseling Services and Health Services may exchange information about my care

____ No, Counseling Services and Health Services may NOT exchange information about my care

To provide the best help for you, the counselors within Counseling Services may consult with each other regarding our work with you. If we need to consult with professionals outside of this department, no identifying information will be released without your written authorization (except in those very rare situations described above). Finally, if we come to believe that our services are not or will not be appropriate for you, we may, after discussing our concerns with you, decide to conclude your counseling or refer you to more appropriate services.

If you have questions or concerns about the rights and responsibilities described above, talk with your counselor before signing below. The extra copy is for you to keep.

I have read and I agree to the above rights and responsibilities.

Student Signature _____ _____

Date