

# 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:

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

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

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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

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> recent appetite changes       | <input type="checkbox"/> restless                  | <input type="checkbox"/> rapid heart rate         | <input type="checkbox"/> fears/phobias         |
| <input type="checkbox"/> overeating                    | <input type="checkbox"/> compulsive behaviors      | <input type="checkbox"/> chest pain               | <input type="checkbox"/> vomiting              |
| <input type="checkbox"/> recent weight loss/gain       | <input type="checkbox"/> depressed mood            | <input type="checkbox"/> sweating                 | <input type="checkbox"/> distrust              |
| <input type="checkbox"/> social withdrawal             | <input type="checkbox"/> crying                    | <input type="checkbox"/> trembling or shaking     | <input type="checkbox"/> dizzy or lightheaded  |
| <input type="checkbox"/> family emotional problems     | <input type="checkbox"/> fatigue/loss of energy    | <input type="checkbox"/> shortness of breath      | <input type="checkbox"/> jumpy                 |
| <input type="checkbox"/> sleep disturbance             | <input type="checkbox"/> difficulty concentrating  | <input type="checkbox"/> muscle tension           | <input type="checkbox"/> obsessions            |
| <input type="checkbox"/> experienced a traumatic event | <input type="checkbox"/> low motivation            | <input type="checkbox"/> anxiety                  | <input type="checkbox"/> compulsions           |
| <input type="checkbox"/> decreased need for sleep      | <input type="checkbox"/> suicidal thoughts         | <input type="checkbox"/> odd behavior/thoughts    | <input type="checkbox"/> relationship problems |
| <input type="checkbox"/> easily distracted             | <input type="checkbox"/> feelings of worthlessness | <input type="checkbox"/> nightmares               | <input type="checkbox"/> financial problems    |
| <input type="checkbox"/> can't turn my mind off        | <input type="checkbox"/> stomach problems          | <input type="checkbox"/> drinking alcohol         | <input type="checkbox"/> housing problems      |
| <input type="checkbox"/> outbursts of temper           | <input type="checkbox"/> self harm                 | <input type="checkbox"/> using illicit substances | <input type="checkbox"/> academic problems     |
| <input type="checkbox"/> impulsive behaviors           | <input type="checkbox"/> problems with school      | <input type="checkbox"/> aggressive behavior      | <input type="checkbox"/> other _____           |
| <input type="checkbox"/> mood swings                   | <input type="checkbox"/> pain                      | <input type="checkbox"/> homicidal thoughts       |  |

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.):

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

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**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? \_\_\_\_\_

Think of the occasion that you used other substances in the **past month**.

What did you use? \_\_\_\_\_ Over what period of time? \_\_\_\_\_

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	_____	_____	_____	_____
	_____	_____	_____	_____

Parental Status? \_\_\_\_\_

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.*

The more energy you put into counseling, the more benefits you will receive.

## 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.

I have received a copy of the Americans with Disabilities Act Handout

*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 \_\_\_\_\_

