

Dear Student,

Welcome to Counseling Services at Goucher College. In efforts to inform you of some basic information about our services, please review the information below.

Our Services

Our model provides brief individual counseling which typically ranges from 1 – 12 sessions. The goals of brief psychotherapy are to offer support and/or crisis intervention; resolve problems such as depression, anxiety or maladaptive behavior patterns; enhance self-awareness and interpersonal effectiveness; and learn adaptive coping skills that may be used in the future. In your first visit, your counselor will help you address immediate problems and develop a treatment plan. You and your counselor will collaboratively determine your goals for counseling and what resources will be of benefit to you.

Managing a Crisis

If you are experiencing a crisis or a sense of urgency, Counseling Services has a daily walk-in hour, Monday, Tuesday, Wednesday, and Friday at 1p.m. and Thursday at 2p.m. Urgent Call-In hours are available Saturday and Sunday from 1-4p.m.; a counselor will return your call within an hour of your leaving a message. In case of a psychiatric emergency at any other time, call the Office of Public Safety at 410-337-6112. You can also call 911 or proceed immediately to a local hospital emergency room (GBMC and St. Joe's are in closest proximity).

Privacy and Confidentiality

In general, the privacy of all communications between a client and a counselor are protected by law; information can be released only with your written permission. The only exceptions are those situations in which the therapist has a duty to protect human life, prevent death, or follow legal obligations in regard to reporting child abuse, or in the unlikely event that your records were subpoenaed. Even in these cases, you would be informed whenever possible, and no more information than necessary would be released.

The Counseling Center keeps records as required by law and in accordance with professional and ethical guidelines. With the exceptions noted above, no one other than authorized Counseling Center staff will have access to your records, unless you release them in writing. The records are kept in locked file cabinets, separate from your general health records or academic file. With the exceptions noted above, even the fact that you have come to the Counseling Center will not be divulged to anyone without your permission.

Therapists may consult with supervisors and colleagues in the Health and Counseling Center to improve their skills and to provide clients with the highest quality services possible. This will be done without using a name whenever possible. If the therapist is being supervised, you will be informed of the name of the supervisor. Statistics are compiled on Counseling Center activities, and occasionally the Center staff may make presentations and write articles as part of their work in an academic setting. In these cases, specific identifying information is either absent or highly disguised.

Your Counseling Experience

Please feel free to express how counseling is working for you. If you are planning to discontinue counseling, it is recommended that you attend one last appointment to gain closure. You can reach us at (410) 337 6481.

Sincerely,

Counseling Service Staff

BASIC INFORMATION

Name: _____

Date of Birth: _____ **Age:** _____

ID#: _____

Email address: _____

Phone: _____

Dorm/local address: _____

Anticipated year of graduation: _____

Who referred you to counseling: _____

Reason for seeking counseling: _____

Parent/Guardian: _____

Phone for Parent/Guardian: _____

**Emergency Contact
(if other than parent/guardian):** _____

Email Communication Permission: I give my permission to allow the Counseling Dept. to communicate with me via email. _____

I have read and understood the introduction to counseling letter given to me. Please initial to show assent: _____

Date: _____

Checklist of Concerns

Name: _____ Date: _____

Please mark all of the items below that apply. You may add a note or details in the space next to the concerns checked.

- Abuse—physical, sexual, emotional, neglect (of children or elderly persons), cruelty to animals
- Aggression, violence
- Alcohol use
- Anger, hostility, arguing, irritability
- Anxiety, nervousness
- Attention, concentration, distractibility
- Career concerns, goals, and choices
- Childhood issues (your own childhood)
- Codependence
- Confusion
- Compulsions
- Decision making, indecision, mixed feelings, putting off decisions
- Delusions (false ideas)
- Dependence
- Depression, low mood, sadness, crying
- Divorce, separation
- Drug use—prescription medications, over-the-counter medications, street drugs
- Eating problems—overeating, undereating, appetite, vomiting (see also “Weight and diet issues”)
- Emptiness
- Failure
- Family stress
- Fatigue, tiredness, low energy
- Fears, phobias
- Financial or money troubles, debt, impulsive spending, low income
- Friendships
- Gambling
- Grieving, mourning, deaths, losses, divorce
- Guilt
- Headaches, other kinds of pains
- Health, illness, medical concerns, physical problems
- Housework/chores—quality, schedules, sharing duties
- Inferiority feelings
- Interpersonal conflicts
- Impulsiveness, loss of control, outbursts
- Intimate relationships: conflict, distance/coldness, infidelity/affairs, different expectations, disappointments

- Irresponsibility
- Judgment problems, risk taking
- Legal matters, charges, suits
- Loneliness
- Memory problems
- Menstrual problems, PMS, menopause
- Mood swings
- Motivation, laziness
- Nervousness, tension
- Obsessions, compulsions (thoughts or actions that repeat themselves)
- Oversensitivity to rejection
- Pain, chronic
- Panic or anxiety attacks
- Perfectionism
- Pessimism
- Procrastination, work inhibitions, laziness
- Relationship problems (with friends, with relatives, or at work)
- School problems
- Self-centeredness
- Self-esteem
- Self-neglect, poor self-care
- Sexual issues, dysfunctions, conflicts, desire differences, other (see also "Abuse")
- Shyness, oversensitivity to criticism
- Sleep problems—too much, too little, insomnia, nightmares
- Smoking and tobacco use
- Spiritual, religious, moral, ethical issues
- Stress, relaxation, stress management, stress disorders, tension
- Suspiciousness, distrust
- Suicidal thoughts
- Temper problems, self-control, low frustration tolerance
- Thought disorganization and confusion
- Threats, violence
- Weight and diet issues
- Withdrawal, isolating

Other concerns or issues:

Please look back over the concerns you have checked off and choose the one that you most want help with.

It is:

STUDENT HEALTH AND
COUNSELING SERVICES

In efforts to make the best use of our time in session, please give thought to and complete these questions. Some may require you to gather specific information; others may be best answered by having time to think about them. The content will become part of your confidential record and subject to the same legal protections. If you have previously completed this form, please complete only portions that have changed.

What would you like to see happen or change by engaging in counseling now?

What are you looking for from the therapy process (support, listening, skills, other?)

How do you tend to cope with stressors?

What do you see as your strengths (abilities, resources, personality, feelings, habits, relationships)?

Current Medication	Dose	Reason	Prescribing M.D.	Effectiveness (1-10)	Side Effects

Any prior psyc medications	When?	Reason	With what results?

NAME: _____

PREVIOUS TREATMENT

Have you been hospitalized for psychiatric or drug/alcohol treatment? YES___ NO___

Where?	When?	For how long?	Reason?

Have you received outpatient psychological, psychiatric, drug/alcohol treatment before? YES___ NO___

With whom? _____ When? _____

For what? _____

Reason terminated? _____

What worked well? _____

If dissatisfied with process, why? _____

Are you willing to provide release of communication to permit me to speak with this provider? YES NO

With whom? _____ When? _____

For what? _____

Reason terminated? _____

What worked well? _____

If dissatisfied with process, why? _____

Are you willing to provide release of communication to permit me to speak with this provider? YES NO

With whom? _____ When? _____

For what? _____

Reason terminated? _____

What worked well? _____

If dissatisfied with process, why? _____

Are you willing to provide release of communication to permit me to speak with this provider? YES NO