

Informed Consent for Student Counseling Center

The Intake

The purpose of this first visit is to conduct an intake assessment to determine your current clinical needs and make a plan for further treatment and/or support. You and your counselor will collaboratively determine your goals and what resources will be of benefit to you. In the event that the Counseling Center is at full-capacity, you may be added to a waitlist to be seen in our center when a therapy slot becomes available. If treatment needs are immediate while the center is at capacity and operating on a waitlist, your treatment plan will include a referral off-campus for clinical services. Students may be referred to a community provider if it is determined that longer-term care or multiple sessions per week are necessary based upon severity of symptoms. _____ **Initial Here**

Our Services

If you and the clinician agree to begin a course of therapy, it is important to note that our model provides short-term counseling. 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. You and your therapist will work together to determine a treatment plan and goals of this course counseling. The value of therapy comes with consistent attendance at scheduled sessions and active communication between the therapist and client. For missed scheduled appointments that are not cancelled prior to the appointment time, a \$10 fee will be incurred. If you have concerns or plan to discontinue counseling, it is recommended that you discuss these issues with your therapist. Please note that if we have not heard from you for more than 14 days after your last scheduled appointment, we will assume you are no longer interested in our services and will consider the current course of therapy closed. _____ **Initial Here**

Out of Scope of Our Services

It is important to note that certain services are not provided by staff of the Student Counseling Center. Counseling Center staff do not provide educational assessments, assessments and documentation for emotional support animals or service animals, and one time assessments for accommodations or study abroad evaluations. Additionally, the Counseling Center does not provide long-term psychotherapy, therapy occurring more than one time per week, or therapy for disorders that require specialized treatment. _____ **Initial Here**

Managing a Crisis

If you are experiencing a crisis or a sense of urgency, the Counseling Center has a daily walk-in time slot, Monday through Friday at 1:00pm. If you are in need of urgent mental health support outside of normal business hours, call 855-236-4278. Goucher Student Counseling Center has partnered with ProtoCall to ensure students have access to mental health support outside of normal business hours. This service integrates seamlessly with the Counseling Center. You can also call the Office of Public Safety at 410-337-6112 or 911. _____ **Initial Here**

Privacy and Confidentiality

The Counseling Center keeps records as required by law and in accordance with professional and ethical guidelines. Records are stored electronically on a dedicated, secure server maintained by the college's IT department with access restricted to Counseling Center clinical staff. Mental health records are kept separate from health and academic records. 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. There are only limited exceptions to this rule, including those situations in which the therapist has a duty to protect human life, prevent death, follow legal obligations in regard to reporting abuse/neglect of vulnerable populations, or in the unlikely event of a court-order to release records. Even in these cases, you would be informed of the disclosure whenever possible, and no more information than necessary would be released. 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. For students who are being referred from the Office of the Dean of Students, a release of information will be obtained to communicate only necessary information regarding your attendance of assessment. _____ **Initial Here**

Therapists may consult with supervisors and colleagues in the Counseling Center to improve their skills and to provide clients with the highest quality services possible. If the therapist is being supervised, you will be informed of the name of the supervisor who will review and cosign all documentation. 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.

I have read and understood the introduction to counseling letter given to me. Please sign to show consent:

Student's Signature _____ Date _____

I have verbally discussed this information with the student.

Clinician's Signature _____ Date _____

Personal Information

First name: _____ Middle name: _____

Last name: _____

Preferred name: _____ Pronouns: _____

Student ID: _____ DOB: _____

Cell Phone: _____ Email: _____

Please initial here to allow Counseling staff to communicate with you via email _____

Local Address/Residence Hall _____

Gender identity: _____

Race/Ethnicity: _____

Country of origin: _____

International student: Yes / No Are you a first generation student? Yes / No Are you first generation American? Yes / No

Sexual orientation: _____

Program: Undergrad / Postbac / Other Year: _____ Graduation Year: _____

GPA: _____

Are you registered with the Goucher Office of Accessibility as having a documented and diagnosed disability? Yes / No

Housing: On-campus / Off-campus

Athlete? Yes / No

Religion: _____

Emergency Contact Name: _____

Emergency Contact Relationship: _____

Emergency Contact Phone: _____

Who referred you to the Counseling Center? _____

Have you previously been seen in Student Counseling Center? _____

Please write your full availability for Follow-Up/Counseling Sessions (Counseling Hours M,T,&Tr 9am-7pm & W&F 9am-5pm):

| Monday | Tuesday | Wednesday | Thursday | Friday |
|--------|---------|-----------|----------|--------|
| | | | | |

Concerns

Please check off your primary concerns:

| | |
|--|---|
| <input type="checkbox"/> Anxiety <input type="checkbox"/> Generalized <input type="checkbox"/> Social <input type="checkbox"/> Panic attack(s) <input type="checkbox"/> Test taking <input type="checkbox"/> Specific Phobia <input type="checkbox"/> Unspecified/other <input type="checkbox"/> Obsessions or compulsions <input type="checkbox"/> Perfectionism <input type="checkbox"/> Stress <input type="checkbox"/> Depression <input type="checkbox"/> Mood instability <input type="checkbox"/> Emotional dysregulation <input type="checkbox"/> Anger management <input type="checkbox"/> Relationship problem (specific) <input type="checkbox"/> Interpersonal functioning <input type="checkbox"/> Social isolation <input type="checkbox"/> Family <input type="checkbox"/> Grief/Loss <input type="checkbox"/> Health/medical <input type="checkbox"/> Eating/body image <input type="checkbox"/> Sleep <input type="checkbox"/> Sexual concern <input type="checkbox"/> Pregnancy related <input type="checkbox"/> Identity development <input type="checkbox"/> Self-esteem/confidence <input type="checkbox"/> Adjustment to new environment | <input type="checkbox"/> Racial, ethnic, or cultural concerns <input type="checkbox"/> Sexual orientation <input type="checkbox"/> Gender identity <input type="checkbox"/> Religion/spirituality <input type="checkbox"/> Discrimination <input type="checkbox"/> Academic Performance <input type="checkbox"/> Career <input type="checkbox"/> Attention difficulties <input type="checkbox"/> Autism spectrum <input type="checkbox"/> Learning disorder/disability <input type="checkbox"/> Alcohol <input type="checkbox"/> Drugs <input type="checkbox"/> Addiction (not drugs or alcohol) <input type="checkbox"/> Self-injurious thoughts or behaviors <input type="checkbox"/> Suicidal thoughts or behaviors <input type="checkbox"/> Violent thoughts or behaviors towards others <input type="checkbox"/> Psychotic thoughts or behaviors <input type="checkbox"/> Dissociative experiences <input type="checkbox"/> Trauma <input type="checkbox"/> Physical abuse/assault (victim) <input type="checkbox"/> Sexual abuse/assault (victim) <input type="checkbox"/> Harassment/emotional abuse (victim) <input type="checkbox"/> Stalking (victim) <input type="checkbox"/> Financial <input type="checkbox"/> Legal/judicial/conduct <input type="checkbox"/> None |
|--|---|

Other: _____

Choose the **ONE** top concern of those checked above: _____

INSTRUCTIONS: The following statements describe thoughts, feelings, and behaviors that people may have. Please indicate how well each statement describes you, during the past two weeks, from “Not at all like me” (0) to “Extremely like me” (4), by circling the correct number. Read each statement carefully, select only one answer per statement, and please do not skip any questions. If while answering any of these questions you determine that you are an imminent risk to yourself or others, please review “Managing a Crisis” on the first page of this packet and utilize the appropriate resources.

| | | | | | |
|---|---|---|---|---|---|
| 1. I am shy around others. | 0 | 1 | 2 | 3 | 4 |
| 2. My heart races for no good reason. | 0 | 1 | 2 | 3 | 4 |
| 3. I feel out of control when I eat. | 0 | 1 | 2 | 3 | 4 |
| 4. I don't enjoy being around people as much as I used to. | 0 | 1 | 2 | 3 | 4 |
| 5. I feel isolated and alone. | 0 | 1 | 2 | 3 | 4 |
| 6. I think about food more than I would like to. | 0 | 1 | 2 | 3 | 4 |
| 7. I am anxious that I might have a panic attack while in public. | 0 | 1 | 2 | 3 | 4 |
| 8. I feel confident that I can succeed academically. | 0 | 1 | 2 | 3 | 4 |
| 9. I have sleep difficulties. | 0 | 1 | 2 | 3 | 4 |
| 10. My thoughts are racing. | 0 | 1 | 2 | 3 | 4 |
| 11. I feel worthless. | 0 | 1 | 2 | 3 | 4 |
| 12. I feel helpless. | 0 | 1 | 2 | 3 | 4 |
| 13. I eat too much. | 0 | 1 | 2 | 3 | 4 |
| 14. I drink alcohol frequently. | 0 | 1 | 2 | 3 | 4 |
| 15. I have spells of terror or panic. | 0 | 1 | 2 | 3 | 4 |
| 16. When I drink alcohol I can't remember what happened. | 0 | 1 | 2 | 3 | 4 |
| 17. I feel tense. | 0 | 1 | 2 | 3 | 4 |
| 18. I have difficulty controlling my temper. | 0 | 1 | 2 | 3 | 4 |
| 19. I make friends easily. | 0 | 1 | 2 | 3 | 4 |
| 20. I sometimes feel like breaking or smashing things. | 0 | 1 | 2 | 3 | 4 |
| 21. I feel sad all of the time. | 0 | 1 | 2 | 3 | 4 |
| 22. I am concerned other people do not like me. | 0 | 1 | 2 | 3 | 4 |
| 23. I get angry easily. | 0 | 1 | 2 | 3 | 4 |
| 24. I feel uncomfortable around people I don't know. | 0 | 1 | 2 | 3 | 4 |
| 25. I have thoughts of ending my life. | 0 | 1 | 2 | 3 | 4 |
| 26. I feel self-conscious around others. | 0 | 1 | 2 | 3 | 4 |
| 27. I drink more than I should. | 0 | 1 | 2 | 3 | 4 |
| 28. I am not able to concentrate as well as usual. | 0 | 1 | 2 | 3 | 4 |
| 29. I am afraid I may lose control and act violently. | 0 | 1 | 2 | 3 | 4 |
| 30. It's hard to stay motivated for my classes. | 0 | 1 | 2 | 3 | 4 |
| 31. I have done something I have regretted because of drinking. | 0 | 1 | 2 | 3 | 4 |
| 32. I frequently get into arguments. | 0 | 1 | 2 | 3 | 4 |
| 33. I am unable to keep up with my schoolwork. | 0 | 1 | 2 | 3 | 4 |
| 34. I have thoughts of hurting others. | 0 | 1 | 2 | 3 | 4 |

CLINICAL HISTORY *Please attach additional sheet if more space is needed

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

| Any prior psyc medications | When? | Reason | With what results? |
|----------------------------|-------|--------|--------------------|
| | | | |
| | | | |
| | | | |

PREVIOUS TREATMENT

Have you ever received outpatient therapy (psychological, psychiatric, drug/alcohol)? YES___ NO___

| Therapist Name | Dates of Service | Reasons for Treatment | Reason for Termination |
|----------------|------------------|-----------------------|------------------------|
| | | | |
| | | | |
| | | | |
| | | | |

Are you willing to provide release of communication to permit me to speak with these providers? YES___ NO___

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

| Where? | When? | For how long? | Reason? |
|--------|-------|---------------|---------|
| | | | |
| | | | |