GOUCHER college
STUDENT COUNSELING SERVICES

# Mental Health Informed Consent

**Our Services**

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. 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. 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. 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**

**Managing a Crisis**

If you are experiencing a crisis or a sense of urgency, Counseling Services has a daily walk-in hour, 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 Counseling Services has partnered with ProtoCall to ensure students have access to mental health support outside of normal business hours. This service integrates seamlessly with Goucher Counseling Services. You can also call the Office of Public Safety at 410-337-6112 or 911. _____ **Initial Here**

**Privacy and Confidentiality**

The Counseling Services 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 Services 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 Services will not be divulged to anyone without your permission. _____ **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 _____

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# Personal Information

**First name:** _____ **Middle name:** _____

**Last name:** _____

**Preferred name:** _____ **Preferred pronouns**: _____

**Student ID:** _____

**DOB:** _____

**Cell Phone:** _____

**Email:** _____

**Local Address:** _____

_____

**Gender identity:** _____

**Race/Ethnicity:** _____

**Country of origin:** _____

**International student:** Yes / No

**Are you the first generation in your family to attend college?** Yes / No

**Are you first generation American?** Yes / No

**Sexual orientation:** _____

**Program:** Undergrad / Postbac / Other

**Graduation Year:** _____

**GPA:** _____

**Are you registered with the Office of Accessibility on this campus 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?** _____

Name:_____ Date:_____

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# Concerns

Please check off your primary concerns:

| | |
|---|---|
| ☐ Anxiety | ☐ Academic Performance |
| ☐ Obsessions or compulsions | ☐ Career |
| ☐ Perfectionism | ☐ Attention difficulties |
| ☐ Stress | |
| | ☐ Alcohol |
| ☐ Depression | ☐ Drugs |
| ☐ Mood instability | ☐ Addiction (not drugs or alcohol) |
| ☐ Anger management | ☐ Self-injurious thoughts or behaviors |
| | |
| ☐ Relationship problem (specific) | ☐ Suicidal thoughts or behaviors |
| ☐ Interpersonal functioning | ☐ Violent thoughts or behaviors towards others |
| ☐ Social isolation | ☐ Psychotic thoughts or behaviors |
| ☐ Family | |
| ☐ Grief/Loss | ☐ Trauma |
| | ☐ Physical abuse/assault (victim) |
| ☐ Health/medical | ☐ Sexual abuse/assault (victim) |
| ☐ Eating/body image | ☐ Harassment/emotional abuse (victim) |
| ☐ Sleep | ☐ Stalking (victim) |
| ☐ Sexual concern | |
| ☐ Pregnancy related | ☐ Financial |
| | ☐ Legal/judicial/conduct |
| ☐ Identity development | |
| ☐ Self-esteem/confidence | ☐ None |
| ☐ Adjustment to new environment | |
| | |
| ☐ Racial, ethnic, or cultural concerns | |
| ☐ Sexual orientation | |
| ☐ Gender identity | |
| ☐ Religion/spirituality | |
| ☐ Discrimination | |

☐ Other: _____

_____

_____

_____

Choose the top concern of those checked above: _____

Name:_____ Date:_____

**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 fee 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 |

Name:_____ Date:_____

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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 | Date Started | Prescribing M.D. | Effectiveness (1-10) | Side Effects |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |

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

***Please attach additional sheet if more space in needed***

Name:_____ Date:_____

**PREVIOUS TREATMENT**

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

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

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

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

Name:_____ Date:_____