Informed Consent for Student Counseling Services

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 Counseling Services 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**

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. 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 _______________

1021 Dulaney Valley Road, Baltimore, MD 21204
410-337-6481 (phone)
410-337-3000(fax)

Updated 8.24.18

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 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? ____

Have you previously been seen in Student Counseling Services? _______________________________________

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

Name:____ Date: _____________________________________ Updated 8.24.18

Concerns

Please check off your primary concerns:

- ☐ Anxiety
- ☐ Generalized
- ☐ Social
- ☐ Panic attack(s)
- ☐ Test taking
- ☐ Specific Phobia
- ☐ Unspecified/other
- ☐ Obsessions or compulsions
- ☐ Perfectionism
- ☐ Stress

- ☐ Depression
- ☐ Mood instability
- ☐ Emotional dysregulation
- ☐ Anger management

- ☐ Relationship problem (specific)
- ☐ Interpersonal functioning
- ☐ Social isolation
- ☐ Family
- ☐ Grief/Loss

- ☐ Health/medical
- ☐ Eating/body image
- ☐ Sleep
- ☐ Sexual concern
- ☐ Pregnancy related

- ☐ Identity development
- ☐ Self-esteem/confidence
- ☐ Adjustment to new environment

- ☐ Racial, ethnic, or cultural concerns
- ☐ Sexual orientation
- ☐ Gender identity
- ☐ Religion/spirituality
- ☐ Discrimination

- ☐ Academic Performance
- ☐ Career

- ☐ Attention difficulties
- ☐ Autism spectrum
- ☐ Learning disorder/disability

- ☐ Alcohol
- ☐ Drugs
- ☐ Addiction (not drugs or alcohol)

- ☐ Self-injurious thoughts or behaviors
- ☐ Suicidal thoughts or behaviors
- ☐ Violent thoughts or behaviors towards others
- ☐ Psychotic thoughts or behaviors
- ☐ Dissociative experiences

- ☐ Trauma
- ☐ Physical abuse/assault (victim)
- ☐ Sexual abuse/assault (victim)
- ☐ Harassment/emotional abuse (victim)
- ☐ Stalking (victim)

- ☐ Financial
- ☐ Legal/judicial/conduct

- ☐ None

☐ Other: ____

____

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

Name:____ Date: ___________________________________ Updated 8.24.18

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.

Statement					
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?