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 ____________

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:

____

____

____

____

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

____

____

____

____

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

____

____

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

__overeating
__taking drugs
__odd behavior/thoughts
__recent weight gain
__recent weight loss
__recent appetite changes
__social withdrawal
__family emotional problems
__chest pain
__difficulty falling asleep
__difficulty staying asleep
__experienced a traumatic event
__restless
__depressed mood
__crying
__difficulty concentrating
__low motivation
__aggressive behavior
__feelings of worthlessness
__stomach problems
__sleeping too much
__problems with school
__pain
__financial problems
__rapid heart rate
__sweating
__trembling or shaking
__shortness of breath
__muscle tension
__outbursts of temper
__nightmares
__easily distracted
__decreased need for sleep
__housing problems
__drinking alcohol
__can't turn my mind off
__compulsive behaviors
__impulsive behaviors
__fears/phobias
__anxiety
__vomiting
__distrust
__jumpy
__dizzy or lightheaded
__fatigue/loss of energy
__obsessions
__relationship problems
__other: _______________

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.):

____

____

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

____

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? ____________
If applicable, other substances used ______________________________________

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				

Parents marital status (i.e. married, divorced, separated, never married, etc): ______________________

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.*

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.

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