Please bring all completed documents to the first appointment

WABASH COLLEGE COUNSELING CENTER

**Crawfordsville, IN 47933**

**VOLUNTARY CONSENT FOR MENTAL HEALTH SERVICES**:

I, the undersigned, agree and consent to the mental health services offered and provided by the Wabash College Counseling Center.

Wabash College Counseling Center has retained the services of licensed mental health professionals who provide various mental health services. I understand that I am consenting and agreeing only to those mental health services that are within the scope of the practitioner’s license, certification and training.

By signing my name below, I certify that I have read this consent form and agree to all the provisions contained in it.

By signing my name, I also certify that the practitioner \_\_\_ **may** , or \_\_\_ **may not** (check one) contact me by e-mail, which is not a confidential form of communication.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client Signature of Witness

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Date

**IF the client is a minor, or otherwise incompetent to give consent, complete the following:**

\_\_\_ Client is a minor ( \_\_\_ years of age )

\_\_\_ Client is not a minor, but is unable to give consent because: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For and on behalf of the client, I hereby execute the foregoing consent form, and I represent that I am authorized to do so.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent, Guardian or Other Signature of Witness Date

Person Signing for Client

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Parent, Guardian or Relationship of Person Signing for Client

Person Signing for Client

 **Wabash College Counseling Center - Client Rights**

* **To participate in and to consent to treatment.**
* **To participate in developing an individual plan of treatment.**
* **To receive an explanation of services in accordance with the treatment plan.**
* **To object to, or terminate, treatment.**
* **To have records protected by confidentiality and not be revealed to anyone without client’s written authorization, except where authorized by Federal and State law.**
* **To have access to a summary of one’s records.**
* **To receive clinically appropriate care and treatment that is suited to their needs or to be directed where such care may be available.**
* **To be treated in a manner that is ethical and free from abuse, discrimination, mistreatment, and/or exploitation.**
* **To be treated by staff who are sensitive to one’s cultural background.**
* **To be free to report grievances regarding services, or staff, to the Dean of Students.**
* **To be informed of expected results of all therapies prescribed, including their possible adverse effects.**
* **To request a change in counselor.**

8/12

# Please bring all completed documents to the first appointment

# Wabash College Counseling Center

# Crawfordsville, IN 47933

# (765) 361-6252

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received the ***Family Educational Rights and Privacy Act (FERPA) Guidelines for Wabash College***.

Client’s Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8/12

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Family Educational Rights and Privacy Act (FERPA)

Guidelines for

# Wabash College

## Wabash College

## Office of the Registrar

## P.O. Box 352

301 W. Wabash

Crawfordsville, IN 47933

765-361-6245

**Availability of Student Records and Graduation Rates**

The Registrar's Office will not release academic information (transcripts, grade averages, class rank, etc.) electronically (telephone, fax, or e-mail) to any individual, including the student. Requests for such information must be submitted in writing bearing the student's signature. Faxed requests are acceptable provided they bear the student's signature. E-mail requests are acceptable providing they have a letter bearing the student's **handwritten** signature attached. Please allow two working days for processing of information and transcript requests.

Replacement diplomas will NOT be issued in any name other than that certified (on record) at the time of graduation.

**Student Education Records**

The Family Educational Rights and Privacy Act (FERPA) provides certain rights with respect to education records. These rights include:

(1) **The right to inspect and review the student's education records within 45 days of the day the College receives a request for access**. A student should submit to the Registrar a written request that identifies the record(s) to be inspected. The registrar will make arrangements for access and notify the student of the time and place during regular business hours where the records may be inspected. A Wabash official will be present during the inspection.

(2) **The right to request the amendment of the student’s education records that the student believes are inaccurate, misleading, or otherwise in violation of the student’s privacy rights under FERPA**. A student who wishes to ask the College to amend a record should write the College official responsible for the record, clearly identify the part of the record the requester wants changed, specify why it should be changed, and send a copy of the letter to the Registrar as well. If the College decides not to amend the record as requested, the College will notify the student in writing of the decision and the student’s right to a hearing re­garding the request for amendment. Additional information regarding the hearing procedures will be provided to the student when notified of the right to a hearing.

(3) **The right to provide written consent before the College discloses personally identifiable information from the student's education records, except to the extent that FERPA authorizes** disclosure without con­sent. FERPA permits the College to release education records to the parents of a dependent student without the student's prior written consent. A parent must submit sufficient proof of identity and student dependency before he or she will be permitted to receive an education record under this exception. The College may also disclose education records without a student’s prior written consent under the FERPA exception for disclosure to school officials with legitimate educational interests. A school official is a person employed by the College in an administrative, supervisory, academic or research, or support staff position (including security personnel and health staff); a person or company with whom the College has contracted as its agent to provide a service instead of using College employees or officials (such as an attorney, auditor, or collection agent); a person serving on the Board of Trustees; or a student assisting another school official in performing his or her tasks. A school official has a legitimate educational interest if the official needs to review an educa­tion record in order to fulfill his or her professional responsibilities for the College. Upon request, the College also discloses education records without the student's written consent to offi­cials of another school in which a student seeks or intends to enroll. FERPA also permits the College to disclose without a student's prior written consent appropriately designated "directory information," which includes the Wabash student’s name; his local college, home, and cell phone numbers; local college and home address; e-mail or other electronic messaging address; age; major field of study; participation in officially recognized activities and sports; class standing; weight and height of members of athletic teams; honors, awards, and scholarships earned; photographs; dates of attendance; degree received; post-graduate plans; and most recent previous educational agency or institution attended. A request that directory information not be released without prior written consent may be filed in writing with the Registrar two weeks prior to enrollment. The foregoing list of FERPA exceptions is illustrative and not exclusive; there are additional FERPA exceptions from the prior written consent requirement. In addition, the Solomon Amendment requires the College to grant military recruiters access to campus and to provide them with student recruitment information, which includes student name, address, telephone listing, age or year of birth, place of birth, level of education or degrees received, most recent educational institution attended, and current major(s).

 (4) **The right to file a complaint with the U.S. Department of Education concerning alleged failures by the College to comply with the requirements of FERPA**. The name and address of the Office that administers FERPA is:

 **Family Policy Compliance Office**

 **U.S. Department of Education**

 **400 Maryland Avenue, SW**

 **Washington, DC 20202-5901**

Please bring all completed documents to the first appointment

**Wabash College Counseling Center**

Chapel – Lower Level

Crawfordsville, IN 47933

# Client Information

**Client Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Age**: \_\_\_\_\_\_**DOB**:\_\_\_\_\_\_\_\_\_\_ **Date Completed**: \_\_\_\_\_\_\_\_\_\_\_

**Client Type:** \_\_\_\_\_ Student \_\_\_\_\_Student Dependent \_\_\_\_\_Other **Gender:** Male \_\_\_\_\_ Female \_\_\_\_\_

**Class:** \_\_\_\_\_\_Freshman \_\_\_\_\_\_Sophomore \_\_\_\_\_\_Junior \_\_\_\_\_\_Senior Grad.Year: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Initial Status:** \_\_\_\_\_ Request for Counseling \_\_\_\_\_General Information \_\_\_\_\_ Crisis Contact

**Referral Source:** \_\_\_\_\_ Self- Referral \_\_\_\_\_Faculty Referral \_\_\_\_\_\_ Staff Referral \_\_\_\_\_ Physician Referral

**Referring Person/Program** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Living Unit**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Recent Change? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Campus Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Street-Route) (City) (State) (Zip)

**Home Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Street-Route) (City) (State) (Zip)

**Where would you like to receive *Confidential Mail* ? (check all that apply)**

Email \_\_\_\_\_ Email Address? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Note: Information sent over the internet may not be able to be protected )

Campus Address \_\_\_\_\_ Home Address \_\_\_\_\_ **Send** **No Confidential Mail** \_\_\_\_\_\_

**How can you be reached by phone?**

Cell Ph:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ( Note: Conversations over cell networks may not be secure or private)

Campus Ph:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Ph:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Best time to call \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Additional Authorized Contacts \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Rel. \_\_\_\_\_\_\_\_\_\_\_

 **Please call me at: Cell \_\_\_\_\_ Campus \_\_\_\_\_ Home \_\_\_\_\_ Is it OK to leave a confidential message? Yes No**

**Student Ethnicity/Country of Origin**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Marital Status**: \_\_\_\_\_\_\_\_\_ **How Long:\_\_\_\_\_** # of children:\_\_\_\_\_\_\_\_

Education: (highest year completed) \_\_\_\_\_Currently in school? Yes No Major/Degree: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Work (include ESH): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time in current position \_\_\_\_\_\_ Organization\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Jobs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Military veteran? \_\_\_\_\_\_

**What concerns/issues brought you here? Why now? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Other possible areas of concern that you may be experiencing (please check all that apply):

\_\_\_\_\_Family Relationships \_\_\_\_\_Marital Relationships \_\_\_\_\_School/Academic Issues

\_\_\_\_\_Problems with Temper or Anger \_\_\_\_\_Another’s Alcohol/Drugs \_\_\_\_\_Stress

\_\_\_\_\_Social Relationships \_\_\_\_\_Physical/Medical \_\_\_\_\_Legal

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Wabash College Counseling Center Client Information Pg 2**

Client Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever seen a professional for counseling? Yes \_\_\_\_\_\_ No \_\_\_\_\_\_ If yes, who: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently in counseling? Yes \_\_\_\_\_\_ No \_\_\_\_\_\_ Where/ Last session? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who is your primary care physician?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other specialty care physician? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all physical conditions you have been treated for in the past?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you a current patient at the Student Health Clinic? Yes \_\_\_\_ No \_\_\_\_ Past patient? Yes \_\_\_\_ No \_\_\_\_

For what?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you presently taking a prescribed medication?

Yes \_\_\_\_\_\_ No \_\_\_\_\_\_, What: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you taken a prescribed medication in the past? (Include any meds for Anxiety, Depression, Sleep, ADD, etc.)

Yes \_\_\_\_\_\_ No \_\_\_\_\_\_, What: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Have you used **ANY** alcohol in the last 6 months? **Yes \_\_\_\_\_\_ No \_\_\_\_\_\_ Last use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

How often do you have a drink containing alcohol?

 **\_\_\_\_\_ Never \_\_\_\_ Monthly or less \_\_\_\_ 2-4 times a month \_\_\_\_ 2-3 times a week \_\_\_\_ 4 or more times a week**

How many drinks containing alcohol do you have on a typical day of drinking**? \_ 1 or 2 \_ 3 or 4 \_ 5 or 6 \_ 7 to 9 \_ 10 +**

How often do you have five or more drinks on one occasion**?**

 **\_\_ Never \_\_ Less than monthly \_\_ Monthly \_\_ Weekly \_\_ Dailey or almost daily**

How do you describe your use of alcohol? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever used **ANY** other drug(s) or abused prescription drugs? Yes \_\_\_\_\_\_ No \_\_\_\_\_\_

 Recently used what drug(s)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 How often do you use?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Amount when used? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

What drugs have you abused in the past? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your use of alcohol or drugs increased or decreased in the last 6 mo ? Why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any history of legal charges, job/school consequences, or loss of relationship due to alcohol &/or drugs Yes \_\_\_\_ No \_\_\_\_

Have you ever received treatment because of your alcohol or drug use? Yes \_\_\_\_\_\_ No \_\_\_\_\_\_

Do you or have you ever attended a 12 step meeting or support group? Yes \_\_\_\_\_\_ No \_\_\_\_\_\_

Are you significantly concerned about another person’s use of alcohol/drugs? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Wabash College Counseling Center** **Client Information Pg 3**

Client Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please answer ALL questions**

**ARE you currently, or HAVE you experienced, any of the following: (Circle correct answer)**

* Problemswith sleep? **Y N** Appetite < / >? **Y N** Crying frequently? **Y N** Feeling sad, empty, or hopeless? **Y N**

 Memory problems? **Y N** Thinking/Concentration/Decision problems? **Y N** Loss of interest in daily activities? **Y N**

 Excessive agitation/fatigue? **Y N** Significant weight loss or gain? **Y N**

* Thoughts of harming yourself? Presently? **Y N** In the past month? **Y N**
* Thoughts of harming someone else? Presently? **Y N** In the past month? **Y N**
* History of / or currently a victim of physical or sexual abuse? **Yes No**

**Explain any yes answer above. Anything further you feel I should know?**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Any/other school or job related issues? \_\_\_\_\_\_Absenteeism \_\_\_\_\_\_Tardiness \_\_\_\_\_\_ Confusion

\_\_\_\_\_\_Lack of concentration \_\_\_\_\_\_Temper \_\_\_\_\_Poor quality work \_\_\_\_\_ Problem with peers

\_\_\_\_Difficulty completing tasks \_\_\_\_ Not turning in assignments \_\_\_\_Problems with faculty \_\_\_\_ Problems with staff

\_\_\_\_ Fatigue \_\_\_\_\_ Excessive school activities \_\_\_\_\_Problems with coaching staff \_\_\_\_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The following questions are for referral purposes only.**

#### Health Insurance Carrier: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#### Name of Primary Insured \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Insured’s DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_

***Primary’s Address (if different from client) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grp. #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number for MH/SA Services? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Primary Insured’s company or employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

This above information is true to the best of my knowledge.

 **Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of intake: \_\_\_\_\_\_\_\_\_\_\_\_**

Please bring all completed documents to the first appointment