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 is 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 Person Signing for Client  Signature of Witness  Date

__________________________  __________________________________
Printed Name of Parent, Guardian or  Relationship of 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.

*Please bring the completed documents to the first appointment*
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
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
Client Information

Client Name: ___________________________________________ Age: _______ DOB: ___________ Date: ____________

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


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 _________________________________________________________________
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 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  _____ Daily 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 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? ____________________________________________
Client Name: ____________________________________________________

### PLEASE ANSWER ALL QUESTIONS

**Are you currently or have you experienced any of the following:**

- Problems with sleep? **Y** **N**
- Appetite? **Y** **N**
- Crying frequently? **Y** **N**
- Loss of interest in daily activities? **Y** **N**
  - Memory Problems? **Y** **N**
  - Concentration Problems? **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?
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

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  
- ____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:** ____________