AUGUSTA UNIVERSITY

COUNSELING CENTER INFORMED CONSENT

The Counseling Center adheres to strict confidentiality guidelines set by each professional's national and state ethical codes/guidelines. All conversations, both by telephone and in person, are confidential. Communications will be made by phone and/or email (unless otherwise requested by the client). Any and all records kept by The Counseling Center staff relating to clients 18 years of age or older are kept confidential, except in these cases:

a. When the client is determined to be a threat to the health and safety of self or another, including abuse of a child, elder or disabled adult. If a counselor determines a client's personal safety or the safety of another person is at risk, counselors are required by law to take protective actions. This may include notifying family members or other emergency contacts, contacting the police, seeking hospitalization for the client, notifying potential victims of harm or contacting others who can help provide protection. In the case of abuse, counselors are required by law to notify the appropriate state agency. If any of these situations occur, every effort will be made by your counselor to fully discuss the situation with you before taking any action.
b. When documents are court ordered to be released to the property of the court.
c. When the Counseling Center professional staff/interns discuss case material for the purpose of consultation, supervision, or treatment team planning.
d. When the Counseling Center staff makes a referral on your behalf to Student Health in order to coordinate treatment. Only relevant and pertinent information relating to treatment planning shall be shared.
e. When a CARE Report about a client involves threat of harm to self or other(s).
f. When the client has given consent to share specified information with identified person(s).
g. Clients under age 18 must have a parent/guardian sign this form before treatment begins. The client, counselor and parent(s) will together identify confidentiality parameters for future treatment.
h. Client names and appointment information are shared with front office staff in both the Summerville and Health Science Campus Counseling Center offices for check-in purposes. (Please refer to the Additional Information section below for records management policies.)

ELIGIBILITY FOR SERVICES

The Counseling Center provides individual counseling services to students using a brief counseling model. Brief counseling is often effective for common issues faced by college students and using this model allows us to serve a greater number of clients with our available resources. Most clients attend about 4 to 5 sessions with an 8 session per year limit. The Center will work with students to refer them to an off-campus referral for more long-term, intensive counseling or specialized care, when needed. Clients identified as needing a referral will be assisted with locating an appropriate off-campus mental health provider. Off-campus referrals for family or couples counseling are also available. Current/former clients seeking a graduate internship or graduate assistantship may be excluded from the training program if it appears a harmful/inappropriate dual relationship exists. Counselors who teach academic classes may not counsel students who are enrolled in their course(s). Clients who enroll in their current counselor's class will be required to transfer to a different counselor or discontinue counseling services on campus during that semester.

ADDITIONAL INFORMATION

a. Initial Appointment: During the first appointment, clients will meet with a counselor to discuss the problem that led to seeking counseling and to provide personal history and background information. At the conclusion of the initial meeting, treatment options will be discussed, including whether or not counseling needs may be better met by an off campus counselor or physician. If counseling with the Augusta University Counseling Center is appropriate, future appointments may or may not be with the same counselor depending on scheduling and the nature of the treatment issues.
b. Individual sessions are usually 50 minutes in length. Active participation in the counseling process is necessary for progress. Noncompliance with treatment recommendations may necessitate early termination of services. Your counselor will work with you to help determine what treatment is in your best interest.
c. Hard copy client records are shredded after 7 years. Computerized client records will be deleted after 7 years.
d. Computerized & hard copy client records are accessible only to The Counseling Center staff. The main Counseling Center on the Summerville Campus will be responsible for storing general client records and managing client information related to scheduling appointments. Counseling session records will be maintained separately in the counselor of record's office. Computerized records are password protected. Counseling Center records are *not* part of Augusta University student records.
e. E-mail, mobile phone text messaging/calls and facsimile are not secure media; therefore, confidentiality of e-mail, mobile phone use, and facsimiles cannot be guaranteed. Urgent or emergency communications should not be sent via email or fax since timeliness of response to a facsimile or email message cannot be guaranteed. Social media

such as Facebook, LinkedIn, Twitter, Pinterest, etc. are not appropriate means of communication with your counselor as those media may compromise your confidentiality and privacy and blur the boundaries of the professional counseling relationship. Friend or contact requests sent to counselors by current clients and some former clients will not be accepted. If you and your counselor do choose to communicate via email, those messages should be limited to only administrative purposes, such as cancelling an appointment. Discussion about counseling session content should be limited to face to face or phone communication. If you prefer not to be contacted by email regarding administrative concerns, please indicate that preference on the following form.

f. By signing this document, you are indicating your agreement that your participation in counseling services will not include calling a counselor as a witness in a court proceeding. Be aware that once counseling services are initiated, it is unethical for your counselor to give any opinion/recommendation about issues in a legal/court setting such as custody/visitation arrangements or other legal issues, even if your counselor is compelled by a judge to be a witness. Augusta University counselors are not considered forensic experts in legal matters. If a counselor is required by a judge to testify, counselors are ethically bound not to provide an opinion about a legal matter. Be advised that Augusta University & the Counseling Center will attempt to prevent testimony from occurring.

g. You may be assigned a graduate intern as your counselor; interns receive weekly supervision from a licensed mental health professional.

CLIENT RIGHTS AND RESPONSIBILITIES

a. You have a right to confidentiality within the limitations described above.

b. You have the right to be involved in your goal setting/treatment planning process and to be informed of the professional members of your treatment team. It is the client's responsibility to make a good faith effort to fulfill the treatment recommendations suggested by your therapist. These recommendations include efforts such as attending appointments as suggested by your counselor, being actively involved during sessions, completing homework assignments, following up with a medication evaluation referral and taking medications as prescribed by your physician, experimenting with new ways of doing things, openly and honestly voicing your opinions, thoughts and feelings, whether negative or positive and implementing any crisis response plan recommended by your counselor. If you have concerns about treatment suggestions, you are encouraged to express them to your counselor to avoid any misunderstandings.

c. If during the counseling process your counselor determines he/she is not effective in helping you reach your counseling goals, or if long-term or more specialized treatment is warranted, your counselor is obligated to discuss this with you and if necessary, provide appropriate referrals & terminate treatment. (You have the right to be informed of reason for referral.)

d. You have the right to be informed of any potential benefits or risks associated with your treatment. It is not uncommon for symptoms to worsen before they improve. Participation in counseling can result in a number of benefits to you depending on your counseling goals. Working toward these benefits requires effort on your part.

e. You have the right to refuse treatment and to be involved in determining length and frequency of your treatment.

f. You have the right to receive treatment from competent mental health care professionals who respect your individualized needs.

g. You have the right to request another mental health care professional within the department or a referral to an outside professional. Before requesting a transfer to another in-house therapist, we encourage you to discuss your concerns with your therapist or the Counseling Center Director.

h. For clients 18 years of age or older, access to records/treatment information is available only with a written release of information form, signed by the client.

i. Cancellations must be made at least 24 hours in advance. It is the client's responsibility to reschedule any missed or cancelled appointments. Clients who miss more than 3 appointments per semester may lose eligibility for services. If you are more than 15 minutes late for an appointment, the Center reserves the right to reschedule your appointment.

EMERGENCY SERVICES

In the event of an emergency in which you are unable to reach the Counseling Center, call 9-1-1, the Georgia Crisis and Access Line at 1-800-715-4225, or immediately obtain safe transportation to the nearest hospital emergency room.

I have read and understand the above statements. I have had the opportunity to ask questions about the statements above and have been provided with a copy of the Counseling Center's Explanation of Services and Client Rights and Responsibilities brochure.

Client Signature Date Therapist Signature Date

Parent/Guardian Signature (if client under 18) _____ Date _____

COUNSELING CENTER INTAKE FORM

(**Office Use Only**) Assigned Therapist: _____

Welcome to the Counseling Center. THANK YOU *for taking the time to fill out this form. This information will be used to provide you the best possible services. All information will be kept confidential, subject to the exceptions noted in the Informed Consent form on the previous page.*

Demographic Information

First Name:	Middle:	Last:	Preferred Name:
Date of Birth:		Age:	
Student ID #:		Today's Date:	

WAYS TO CONTACT YOU:	Is it okay to contact you here?	May we leave a message?
Cell number: ( ) -	Y / N	Y / N
Home number: ( ) -	Y / N	Y / N
E-mail _____@augusta.edu	Y / N	
Mailing address: Street: City: State: Zip:	Y / N	

Are you an East Georgia State College student? ☐ Yes ☐ No

Which campus do you spend most of your time? ☐ Summerville ☐ Health Sciences Campus ☐ About Equal

Gender identity: ☐ Male ☐ Female ☐ Transgender ☐ Other Sex a birth: ☐ Male ☐ Female ☐ Intersex

I consider myself to be: ☐ Heterosexual ☐ Gay/Lesbian ☐ Bisexual ☐ Questioning

Emergency Contact: _____ Relationship: _____ Phone #: _____

Are you employed ☐ Yes ☐ No Where employed? _____ Hours/ Week: _____

Do you have health insurance coverage? ☐ Yes ☐ No

GRU student athlete? ☐ Yes ☐ No If yes, which team? _____

Are you an international student? ☐ Yes ☐ No If yes, list native country: _____

Military service status: ☐ Never served ☐ National Guard/Reserves ☐ Active Duty ☐ Veteran

Race/Ethnicity (check all that apply):
☐ African American/Black/African ☐ Asian American/Asian ☐ European American/White/Caucasian
☐ Hispanic/Latino/Latina ☐ Multi-Racial ☐ Other: _____

What is your religious preference? _____ Is religion/spirituality a high priority? ☐ Yes ☐ No

How are you financing school? _____ Are finances a major stressor for you? ☐ Yes ☐ No

Relationship/ Social Information

Which of these statements apply to you? (check all that apply):

☐ My family is supportive of me. ☐ I am happy with my relationship with my family

☐ I have a few supportive friends ☐ I feel content with my friendships ☐ I wish I had more friends

Who is your primary support person(s)? _____

Have you spoken with family/friends about the issues that brought you to counseling? ☐ Yes ☐ No

Do you or your family have financial issues or worries? ☐ Yes ☐ No If yes, describe: _____

_____

Current Relationship Status:

☐ Single/Never Married ☐ Committed Relationship ☐ Engaged (When? _____)

☐ Married (1st marriage? Y N; When?_____) ☐ Separated (When? _____)

☐ Divorced (When? _____) ☐ Widow/Widower? (How long? _____)

☐ Same Sex Civil Union/Domestic partnership

Housing Arrangements:

☐ Off-campus apartment/house ☐ GRU Resident Hall ☐ Other: _____

With whom do you live?

☐ Alone ☐ Spouse/Significant Other ☐ Roommate ☐ Parent/Guardian

☐ Children (age/gender: _____)

☐ List others residing with you and indicate relationship: _____

Who referred you to counseling services: (Check all that apply)

☐ Self ☐ Parents/Relative ☐ Partner/Spouse ☐ Friends ☐ Judicial Office/Dean of Students

☐ Public Safety ☐ Residence Life ☐ GRU Coach (list name): _____

☐ Academic Advisor (list name): _____ ☐ GRU Faculty (list Name): _____

☐ GRU Staff (list Name): _____ ☐ Physician (list name/type): _____

☐ Other (list name):

Academic Information

Augusta University Status/Class Standing:

☐ Freshman ☐ Sophomore ☐ Junior ☐ Senior ☐ Graduate Student, Specify Year: _____

☐ Professional Student ☐ Post Professional ☐ Other: _____

List first semester/year of attendance at GRU: _____

Current GPA: _____ GRU Major/Program: _____

If applicable, describe your current career goals: _____

Have you attended another college? ☐ Yes ☐ No If yes, list school(s) and dates of attendance: _____

_____

Have you ever been on academic probation in college or on graduate school remediation? ☐ Yes ☐ No
If yes, when? _____

Have you ever been on academic suspension in college? ☐ Yes ☐ No If yes, when? _____

Have you had any conduct or disciplinary problems on a college campus? ☐ Yes ☐ No
If yes, describe when and what: _____

Have you had any type of incident at a GRU residence hall in which a Resident Assistant or GRU Public Safety was called? ☐ Yes ☐ No If yes, describe when and what: _____

_____

Describe your current class attendance: ☐ I attend most classes ☐ I don't attend some classes
☐ I frequently miss class ☐ I have stopped attending some or all of my classes

Please estimate how much the problems you are seeking counseling for today are interfering with your academic performance: ☐ None ☐ Mild ☐ Moderate ☐ Significant

Did you experience learning problems in elementary or high school? ☐ None ☐ Some ☐ Significant
If problems were significant, describe: _____

Have you ever been diagnosed with a disability? (Check all that apply)

☐ Attention Deficit/ Hyperactivity Disorder ☐ Neurological Disorder
☐ Deaf or Hard of Hearing ☐ Learning Disability/Disorder
☐ Psychological Disorder/Condition ☐ Mobility Impairment
☐ Speech Impairment ☐ Other _____

Are you registered with the Testing and Disability Services office? ☐ Yes ☐ No
Do you receive any accommodations for your disability? ☐ Yes ☐ No If yes, describe: _____

_____

Imminent Concerns

Please respond to the following items:

1. I have thought about killing myself in the last 7 days	Yes	No
2. I wish I could go to sleep and never wake up	Yes	No
3. I have taken steps to prepare to end my life.	Yes	No
4. I have injured myself (e.g., cutting, burning, hitting self) within the last 7 days	Yes	No
5. I am thinking about harming or killing someone(s)	Yes	No
6. I have recently experienced unwanted physical or sexual contact	Yes	No
7. I have recently seen or heard things others have not seen or heard	Yes	No
8. I have recently experienced something that was extremely scary	Yes	No
9. I have been unable to provide for my own food, clothing, and/or shelter	Yes	No

Presenting Problems

In a sentence or two, please state what brings you in today: _____
_____
_____
_____
_____

Please indicate the reason(s) you are seeking counseling today

- ☐ I am feeling sad or depressed
- ☐ I am concerned about my eating patterns or body image
- ☐ I am struggling with anger
- ☐ I am unsure of my sexual identity or gender identity
- ☐ I often feel other people are out to get me
- ☐ I am struggling with academic-related concerns
- ☐ I haven't had any sleep in the past 72 or more hours
- ☐ I have conduct or legal concerns
- ☐ I have intentionally injured myself in the past month
- ☐ I recently experienced a sexual assault
- ☐ I have experienced abuse (physical/sexual/verbal)
- ☐ I need help with study skills
- ☐ I am struggling with LGBTQ issues
- ☐ I am having panic attacks
- ☐ I am feeling anxious
- ☐ I am experiencing discrimination
- ☐ I am struggling with alcohol/drug problems
- ☐ I am struggling with a relationship difficulty
- ☐ I am concerned I might have ADHD
- ☐ I believe I'm at risk for physical harm
- ☐ I have experienced the death of a loved one
- ☐ I am currently considering suicide
- ☐ I have lack of social support
- ☐ I need help with career planning
- ☐ I am having testing problems
- ☐ I have self-esteem issues
- ☐ I must make a major life decision (e.g. terminate pregnancy, leave school) within days
- ☐ I am currently considering seriously harming someone else
- ☐ I am hearing voices of seeing things that others do not hear or see
- ☐ I have a Campus discipline concern/referral (specify referral person: ____)
- ☐ Other (Specify: _____)

From the concerns listed above, please rate the following:

Issue #1: _____ How long has this issue been a problem? _____

How does this issue affect your overall functioning (i.e., school, work, and personal life)?

☐ Not at all ☐ Mildly ☐ Moderately ☐ Significantly ☐ Very Severely

Issue 2: _____ How long has this issue been a problem? _____

How does this issue affect your overall functioning (i.e., school, work, and personal life)?

☐ Not at all ☐ Mildly ☐ Moderately ☐ Significantly ☐ Very Severely

Issue 3: _____ How long has this issue been a problem? _____

How does this issue affect your overall functioning (i.e., school, work, and personal life)?

☐ Not at all ☐ Mildly ☐ Moderately ☐ Significantly ☐ Very Severely

In general, how much do you like yourself?

Very little 1 2 3 4 5 6 7 8 9 10 Very Much

List three things you like about yourself:

1. _____

2. _____

3. _____

Health History

Are you currently under the care of a physician? ☐ Yes ☐ No If yes, list physician(s) name(s), the type of physician(s) (i.e., family doctor, ob-gyn, etc.) and location of physician's practice(s): _____

_____

Please list any serious medical conditions or health problems: _____

_____

If you are *currently* seeing a counselor, psychologist or psychiatrist, please list name(s) here: _____

_____

Have you received *prior* counseling or related services? ☐ Yes ☐ No If yes, describe each below:

Name of counselor/psychologist/psychiatrist: _____
Where: _____ Length of treatment: _____ When? _____
Problem(s) treated: _____
Outcome (circle one): 1 2 3 4 5 6 7 8 9 10
Much worse No Change Much better

Name of counselor/psychologist/psychiatrist: _____
Where: _____ Length of treatment: _____ When? _____
Problem(s) treated: _____
Outcome (circle one): 1 2 3 4 5 6 7 8 9 10
Much worse No Change Much better

_____

List *current* medications you are taking for any psychological issue(s):

Name of Medication & Strength	Prescribing Physician	How often do you take it?	Date Started	For what condition?

Have you ever previously (not currently) taken any medications for problems related to stress, anxiety, depression, sleep, or any other emotional issue? ☐ Yes ☐ No If yes, please list medications: _____ _____ Were these medications helpful? ☐ Yes ☐ No If no, please describe any problems experienced: _____

List all other *current* medications (include prescriptions, over-the-counter meds, birth control, supplements, etc.):

Name of Medication & Strength	Prescribing Physician	How often do you take it?	Date Started	For what condition?

Have you ever been hospitalized for psychological issues (e.g., suicidal thoughts) and/or substance/drug use? If yes, please list reasons, location and date(s): _____

_____

Does any member(s) of your family have a history of psychiatric/psychological issues? Yes ☐ No ☐
If yes, please describe:

_____

_____

_____

_____

Stressful Life Events History

Have you been a victim of a crime? ☐ Yes ☐ No If yes, describe when and how: _____

_____

Have witnessed a crime? ☐ Yes ☐ No If yes, describe when and how: _____

_____

Have you had any unwanted sexual contact(s)? ☐ Yes ☐ No If yes, when and with whom? _____

_____

Have you experienced harassing, controlling, and/or abusive behavior from another person?
☐ Yes ☐ No If yes, when and with who? _____

Has something happened to you or to someone close to you, or have you witnessed something that was extremely scary, assaulting, and/or life-threatening? ☐ Yes ☐ No If yes, please describe: _____

_____

Did this experience cause you intense fear, helplessness, or worry, or do you experience frequent and/or uncontrollable thoughts or images of it? ☐ Yes ☐ No

If you served in the military, did you have any experiences that have caused repeated worry, fear, or distressing thoughts? ☐ Yes ☐ No If yes, please describe: _____

_____

Legal History

Legal History: ☐ None ☐ Currently on probation (Reason: _____)
☐ Previous Arrests (What charge(s)? _____ When? _____)

☐ DUI conviction(s) (How many? _____ When? _____)

Describe any *current* legal charges: _____

Drug/Alcohol Use History

How often do you drink alcohol? ☐ I do not drink alcohol ☐ Once a week or less
☐ More than once a week ☐ Daily or almost daily

In the last 2 weeks, how often have you had **4 or more** alcoholic drinks (for women) or **5 or more** alcoholic drinks (for men), in one sitting?

☐ None ☐ Once ☐ Twice ☐ 3 to 5 times ☐ 6 to 9 times ☐ 10 or more times

How often do you engage in recreational drug use? ☐ Never ☐ Rarely ☐ Monthly ☐ Weekly
☐ Daily/Almost daily

Please list the types of recreational drugs you have used: _____

_____

Do you consider your alcohol or drug use to be a problem? ☐ Yes ☐ No If yes, describe:

_____

Have others (family, friends, employer, doctor, etc.) expressed concern about your alcohol or drug use?
☐ Yes ☐ No If yes, describe: _____

Having read and completed the questions above, I declare the information I have provided here is correct and complete, to the best of my ability.

Signed: _____ **Date:** _____

Last Revised: 1/25/16