The Counseling Center adheres to strict confidentiality guidelines set by each professional’s national and state ethical codes/guidelines. All communications, 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

<table>
<thead>
<tr>
<th>First Name:</th>
<th>Middle:</th>
<th>Last:</th>
<th>Preferred Name:</th>
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</table>

Date of Birth: Age:  

Student ID #: Today’s Date:  

WAYS TO CONTACT YOU:  

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<tr>
<th>WAYS TO CONTACT YOU:</th>
<th>Is it okay to contact you here?</th>
<th>May we leave a message?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cell number: ( )</td>
<td>Y / N</td>
<td>Y / N</td>
</tr>
<tr>
<td>Home number: ( )</td>
<td>Y / N</td>
<td>Y / N</td>
</tr>
<tr>
<td>E-mail <a href="mailto:___________@augusta.edu">___________@augusta.edu</a></td>
<td>Y / N</td>
<td></td>
</tr>
<tr>
<td>Mailing address: Street:</td>
<td>Y / N</td>
<td></td>
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<tr>
<td>City: State: Zip:</td>
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</table>

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 having panic attacks
☐ I am concerned about my eating patterns or body image ☐ I am feeling anxious
☐ I am struggling with anger ☐ I am experiencing discrimination
☐ I am unsure of my sexual identity or gender identity ☐ I am struggling with alcohol/drug problems
☐ I often feel other people are out to get me ☐ I am struggling with a relationship difficulty
☐ I am struggling with academic-related concerns ☐ I am concerned I might have ADHD
☐ I haven’t had any sleep in the past 72 or more hours ☐ I believe I’m at risk for physical harm
☐ I have conduct or legal concerns ☐ I have experienced the death of a loved one
☐ I have intentionally injured myself in the past month ☐ I am currently considering suicide
☐ I recently experienced a sexual assault ☐ I have lack of social support
☐ I have experienced abuse (physical/sexual/verbal) ☐ I need help with career planning
☐ I need help with study skills ☐ I am having testing problems
☐ I am struggling with LGBTQ issues ☐ 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?

<table>
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<tr>
<th>Very little</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>Very Much</th>
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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):

<table>
<thead>
<tr>
<th>Name of Medication &amp; Strength</th>
<th>Prescribing Physician</th>
<th>How often do you take it?</th>
<th>Date Started</th>
<th>For what condition?</th>
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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.):

<table>
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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