



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. Unless otherwise determined by you and your counselor, clients will be classified as inactive if they haven't met with a counselor in 6 weeks. 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. If you miss an appointment, your counselor might contact you by phone or email to inquire whether you would like to reschedule your appointment or discontinue counseling.

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 _____

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)

- | | |
|--|---|
| <input type="checkbox"/> Attention Deficit/ Hyperactivity Disorder | <input type="checkbox"/> Neurological Disorder |
| <input type="checkbox"/> Deaf or Hard of Hearing | <input type="checkbox"/> Learning Disability/Disorder |
| <input type="checkbox"/> Psychological Disorder/Condition | <input type="checkbox"/> Mobility Impairment |
| <input type="checkbox"/> Speech Impairment | <input type="checkbox"/> 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

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