



Client Informed Consent for Counseling

Counseling & Mental Health Services (CMHS)
Health Services Annex Telephone: 860.486.4705

Website: <http://www.counseling.uconn.edu>

Welcome to Counseling & Mental Health Services at the University of Connecticut. In order to provide the best possible service, it is important for us to provide you information on the services offered. We provide brief treatment. All written and verbal communication derived from counseling and assessment will be held in the strictest professional confidence. Our standards are compliant with Connecticut State Statute and the professional ethics of all the disciplines involved in your treatment. Limits to confidentiality include: 1. if you are a danger to yourself or others; 2. if you are so gravely disabled that you are unable to care for yourself; 3. if you report the abuse or neglect of a minor child or dependent elderly person; or, 4. if a court orders the release of your record. These exceptions are designed to protect you and your community as required by State, Federal and local law. In all other cases, your record will require a written release from you. Your record is available on a need to know basis to University of Connecticut Student Health Services' care providers as Counseling & Mental Health Services are part of Student Health Services. You should be aware that while any of the interventions offered by Counseling & Mental Health Services may offer significant benefits they may also pose risks. Initial assessment, individual psychotherapy, group therapy, and crisis intervention may arouse unpleasant memories, thoughts or emotions. Likewise while often helpful, medications can produce negative side effects.

Initial Assessment: This first meeting is an opportunity for you to define the issues that have brought you to Counseling & Mental Health Services. During this assessment you will participate in developing an individual treatment plan to meet your specific needs and concerns. This treatment plan may include the following service recommendations:

- **Brief crisis intervention:** You will work with a therapist for a couple of sessions to find an intervention that will resolve some aspect of your crisis so that it becomes manageable.
- **Individual psychotherapy:** This is a process in which you will have an opportunity to gain insight and control over issues that are causing disruption in your life or that are an impediment to your progress. Psychotherapy is a cooperative process between the therapist and the client and requires honesty in addressing issues.
- **Group psychotherapy:** This is a format in which a therapist or therapists meet with a small group of clients that consent to maintain confidentiality. Group therapy provides an opportunity for multiple points of view and a wide range of experiences in addressing problems. It is expected that members will contribute their observations to other members. This is a powerful form of treatment particularly suited to address particular issues or styles. Your therapist can help you determine if this would be beneficial.
- **Medication evaluation:** You may be referred to a psychiatrist or an Advanced Practice Registered Nurse (A.P.R.N.) for evaluation for medication. In many instances, the combination of psychotherapy and medication represents the most effective treatment.

Referral: In some instances where long term treatment or specialized services are necessary, you may be given a list of area practitioners. **If you have been referred to CMHS, it is sometimes useful for the referring party to be informed simply that you appeared for this appointment. May we inform the referring source?**

Check one. May inform May not inform.

Referral Name: _____ **Phone#:** _____

Our Staff: Is composed of licensed professionals and graduate students in Clinical Psychology and Social Work. All graduate students receive supervision by licensed staff members. Our licensed staff includes psychiatrists (M.D.), psychologists (Ph.D. or Psy.D.), social workers (L.C.S.W.), and prescribing nurses (A.P.R.N.). We have two full time administrative professionals. In addition, other consultations within Counseling & Mental Health Services may occur in an ongoing effort to provide effective services. Occasionally, outside consultation with appropriate professional personnel may be necessary. You will be notified if you are to see a graduate student.

Hours of Operation: Counseling & Mental Health Services is open from 8:30 AM -4:30 PM, M-F during the academic year with the exception of school vacations and holidays for which the University is closed. After hour non-life threatening emergencies are handled through the on-call system during the academic year, this is accessed by dialing 860-486-4705. During the summer, operation hours are from 8:30 AM- 4:30 PM, M-F and are for medication, crisis intervention, and limited psychotherapy. Counseling & Mental Health Services is closed on national holidays. **IN ALL LIFE THREATENING EMERGENCIES DIAL 911.**

Service Fees per visit: Triage: no charge Initial Assessment/Urgent Initial Assessment: \$10
Reactivation (previously seen patients): \$10 Individual Psychotherapy: \$15 Group Psychotherapy: \$10
Medication Evaluation: \$30 Medication Management: \$15

To protect your confidentiality, service fees may be charged to your fee bill as Health Services Miscellaneous if you wish. Fees may also be paid in cash or by check. If you fail to show for or to cancel a scheduled appointment 24 hours prior to the appointment time you will be charged the cost of the service and the charge will appear on your University fee bill. **Fees are not reimbursable by insurance.**

Any questions regarding this consent form or the services provided by Counseling & Mental Health Services have been discussed with my therapist. I understand that services will be provided by licensed professionals or graduate students under their supervision. I have read and understood the above and I consent to participate in the evaluation and treatment offered by Counseling & Mental Health Services. I will abide by the procedures outlined and will bring to my therapist issues I may have regarding treatment. I understand that I may stop treatment at my discretion.

Client Signature

Date

Therapist Signature

Date

Counseling & Mental Health Services (CMHS)

Client Information Form

Name: _____ Date: ____/____/____
(Print)

Birthdate: ____/____/____ Age: _____ PeopleSoft #: _____

Local Address:

Street/Dormitory Room #: _____

City: _____ State: _____ Zip Code: _____

Telephone #: (____) _____

E-mail Address: _____ Cell #: (____) _____

May We Contact You By: Local Phone: Yes___ No___ E-mail: Yes___ No___

Local Mail: Yes___ No___

Permanent Address:

Street: _____

City: _____ State: _____ Zip Code: _____

Telephone #: (____) _____

Emergency Contact: _____

(name) (relationship)

(____) (____)

(work phone) (home phone)

Referral: Who referred you? Self___ Parent___ Dean of Students___ Court Referral___

RA___ Friend___ Health Services___ Other? _____

Academic Information: Undergraduate ___ Semester Standing _____ Graduate ___ Non-degree ___

Full-time ___ Part-time ___ Current Academic Probation? Y N

Major: _____ GPA: _____

Vocational Objectives: _____

Extracurricular interests/activities: _____

DEMOGRAPHIC INFORMATION

Gender: Male ___ Female ___ Transgender ___ Intersex ___ Other _____

Sexual Orientation: Heterosexual ___ Gay ___ Lesbian ___ Bi-sexual ___ Queer ___

Questioning ___ Other _____

Race/Ethnicity

African/Black, Non-Hispanic _____

Asian/Pacific Islander _____

Caucasian/White, Non-Hispanic _____

Hispanic, Latino(a), Chicano(a) _____

Native American/American Indian _____

Bi-racial/Bi-ethnic _____

Multi-racial/Multi-ethnic _____

Other _____

Veteran Status: _____ **Years of Active Duty:** _____

International Student

Are you an international student? **Y N** If yes, from what country? _____
Are you employed? **Y N** If yes, number of hours per week: _____

FAMILY INFORMATION

Relationship Status: Single_____ Divorced_____ Involved-how long?_____
Widowed_____ Separated_____ Partnered- how long?_____
Civil Union_____ Domestic Partner_____

Partner's Name : _____ Age:_____ Occupation: _____

Children's names and ages:

_____, _____, _____, _____

Religious/Faith Preference: Yours_____ Parent_____ Parent_____

Country of Origin: Yours_____ Parent_____ Parent_____

Parents' Relationship Status _____

If re-Partnered, year: Parent_____ Parent_____

	NAME	AGE (If deceased, give date)	EDUCATION	OCCUPATION
Parent	_____	_____	_____	_____
Parent	_____	_____	_____	_____
Step-parent	_____	_____	_____	_____
Step-parent	_____	_____	_____	_____
Siblings	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

MEDICAL INFORMATION

- Do you have health insurance? (circle one) **YES NO**

Policy Name: _____ **Policy #:** _____

- Please specify any serious illnesses you have or have had:

- Are you presently under medical care? (circle one) **YES NO**

If yes, please specify the reason and the physician's name. _____

- Are you presently taking any medications? (circle one) **YES NO**

- If yes, please specify the medication and dosage (Include oral contraceptives and allergy medications, herbs, over-the-counter medications, and energy drinks).

- Have you ever been hospitalized for medical/substance abuse reasons? (circle one) YES NO

Explain: _____

- List any allergies you have, including allergic reactions to medications: _____, _____, _____, _____, _____

- Do you smoke cigarettes? (circle one) YES NO If so, how much? _____

- Has anyone in your family ever been treated for emotional problems? (circle one) YES NO

If yes, who? _____

When? _____

Type of problem? _____

- Do you or any members of your family abuse (or in the past abused) alcohol, drugs or other substances? (circle one) YES NO

If yes, who? _____

What substances? _____

- Have you ever had any counseling or therapy (individual or group)? (circle one) YES NO

If yes, where and dates: _____

- Have you ever been hospitalized for psychiatric reasons? (circle one) YES NO

If yes, where? _____

When? _____

Reason: _____

- Why have you come to Counseling & Mental Health Services?

Counseling & Mental Health Services

AUDIT QUESTIONNAIRE

1. How often do you have a drink containing alcohol?

- Never Monthly or less Two to Four times a month Two to three times a week
 Four or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?

- 1 or 2 3 or 4 5 or 6 7 to 9 10 or more

3. How often during the last year have you found that you were not able to stop drinking once you started?

- Never Less than monthly Monthly Weekly Daily or almost daily

4. How often during the last year have you been unable to remember what happened when you had been drinking?

- Never Less than monthly Monthly Weekly Daily or almost daily

5. Have you ever had conflicts with peers, authorities or other problems when drinking?

- Yes No

Explain: _____

6. Have you used any illicit drugs in the past twelve months or misused prescription medications?

- Yes No

If yes, drug name _____

Frequency of use _____

Counseling and Mental Health Services

Name _____ Gender _____ Age _____ Date _____

This is a list of problems people sometimes have. For each item, circle in the **Current** column the number that best describes how much that problem has distressed you in the past month. Then, check the **Past** column if you have previously experienced that problem.

0 - NOT AT ALL 1 - A LITTLE BIT 2 - MODERATELY 3 - QUITE A BIT 4 - EXTREMELY

PAST	CURRENT		PAST	CURRENT	
___	0 1 2 3 4	Depression	___	0 1 2 3 4	Bingeing and/or overeating
___	0 1 2 3 4	Feeling empty frequently	___	0 1 2 3 4	Feeling fat
___	0 1 2 3 4	Feeling hopeless	___	0 1 2 3 4	Induced vomiting
___	0 1 2 3 4	Feeling isolated	___	0 1 2 3 4	Self-starvation
___	0 1 2 3 4	Uncontrolled crying	___	0 1 2 3 4	Excessive exercise
___	0 1 2 3 4	Distressing mood changes	___	0 1 2 3 4	Laxative abuse
___	0 1 2 3 4	Suicidal thoughts			
___	0 1 2 3 4	Feeling guilty	___	0 1 2 3 4	Difficulty being assertive
___	0 1 2 3 4	Feeling abandoned	___	0 1 2 3 4	Shyness
___	0 1 2 3 4	Self-injury	___	0 1 2 3 4	Peer relationship problem
			___	0 1 2 3 4	Jealousy
___	0 1 2 3 4	Feeling overwhelmed	___	0 1 2 3 4	Overcontrolled by parents
___	0 1 2 3 4	Difficulty concentrating	___	0 1 2 3 4	Difficulty with authority figures
___	0 1 2 3 4	Sleep problems	___	0 1 2 3 4	Family relationship problems
___	0 1 2 3 4	Change in appetite	___	0 1 2 3 4	Concerns about leaving home
___	0 1 2 3 4	Nightmares	___	0 1 2 3 4	Feeling persecuted
			___	0 1 2 3 4	Romantic relationship problems
___	0 1 2 3 4	Racing heart			
___	0 1 2 3 4	Excessive worrying	___	0 1 2 3 4	Losing temper easily
___	0 1 2 3 4	Anxiety	___	0 1 2 3 4	Unprovoked anger
___	0 1 2 3 4	Panic attacks	___	0 1 2 3 4	Verbal/physical abuse to others
___	0 1 2 3 4	Feeling tense			
___	0 1 2 3 4	Shaking and/or sweating	___	0 1 2 3 4	Academic difficulty
___	0 1 2 3 4	Nausea	___	0 1 2 3 4	Concerns about leaving school
___	0 1 2 3 4	Gastro-intestinal distress	___	0 1 2 3 4	Difficulty making career or academic/major decisions
___	0 1 2 3 4	Compulsions and/or obsessions			
___	0 1 2 3 4	Headaches	___	0 1 2 3 4	Financial problems
___	0 1 2 3 4	Specific fears or phobias			
			___	0 1 2 3 4	Coming out issues
___	0 1 2 3 4	Hyperactivity	___	0 1 2 3 4	Sexual orientation concerns
___	0 1 2 3 4	Excessive energy, spending sprees, or hypersexuality	___	0 1 2 3 4	Sexual problems or concerns
___	0 1 2 3 4	Decreased need for sleep	___	0 1 2 3 4	Physical or sexual assault
___	0 1 2 3 4	Strange or bizarre thoughts	___	0 1 2 3 4	Major traumatic event
			___	0 1 2 3 4	Racial or sexual harassment
			___	0 1 2 3 4	Death of close friend or relative
___	0 1 2 3 4	Drug or alcohol problems	___	0 1 2 3 4	Unwanted pregnancy
___	0 1 2 3 4	Arrest or student discipline	___	0 1 2 3 4	Incest or childhood molestation