Alfred State Health & Wellness

CONFIDENTIAL

The following information is confidential. Please take the time to carefully complete the questions. This will help us to serve you better.

NAME_____ I. D. #_____

Today's Date_____ Date of Birth_____ Sex M_____F_____

Are you under 18 years of age? Yes__ No____

Have you been here before for the following?
_____ Drugs
_____ Alcohol
_____ Anger Management

ETHNIC BACKGROUND (Although answering this question is optional, we ask that you do answer it to help us determine if this office is serving every segment of our student population. As with all answers on this questionnaire, this information will be held in strict confidence.)

Caucasian _____ African American_____
Hispanic/Latino_____ Asian or Pacific Islander_____
American Indian_____ Other_____ Please specify_____

CITIZENSHIP U. S. _____ Other_____

MARITAL STATUS Single_____ Married_____ Divorced_____ Single parent_____

RESIDENCE On campus_____ Off campus_____
College Address_____
Permanent Address_____
Phone No._____ Email address._____

YEAR IN COLLEGE 1st year____2nd year____3rd year_____4th year_____ Anticipated Graduation Date_____
Curriculum Name_____
Associate Degree _____ Bachelor Degree _____
Full time_____ Part-time_____ Non-student_____
Are you having academic problems? Yes_____ No_____
Are you on academic probation? Yes_____ No_____
Have you had counseling before? Yes_____ When_____ Where_____
No_____
Are you currently taking medications? Yes_____ No_____ ***List the medications you are currently taking:*** _____
Are you currently under a doctor's care for any medical problems? Yes_____ No_____
List any physical and/or learning disabilities (optional): _____
_____

How did you learn about Counseling Services ?_____
In the event it is necessary to change or cancel an appointment, may we call you at your current address?
Yes_____ No_____
Is there someone other than you with whom we may leave a message?
_____ No, I do not wish anyone to be contacted.
_____ Yes. Name_____Phone No._____

Were you referred to Counseling Services? Yes_____ No_____
If yes, by whom? Name_____Position_____

Please sign here if you give permission to let the person who referred you know that you did come (no additional information will be shared). Please note: You may choose not to sign. Choosing not to sign will not affect the counseling services you receive here.

Signed_____ Date_____

Rights and Responsibilities for Persons Using Alfred State's Counseling Services

1. You may be assigned to a graduate level counseling intern, who is in training to become a mental health counselor. Please express to the receptionist if you are not comfortable with this assignment. Each intern is supervised closed by a licensed clinician.
2. As a client of the Counseling Services Office, you have certain rights, among which are the rights to: Prompt services, Confidentiality, Respect, Concern for Progress.

Prompt Service: The initial appointment with the intake counselor is for screening/assessment and assignment (if appropriate) to a counselor for weekly counseling sessions, or referral. Weekly counseling will begin as soon as possible after your initial contact at the Counseling Office.

Confidentiality: Information shared by you in a counseling session or through testing will be treated with the strictest confidentiality and will not be disclosed without your permission, except when in the judgment of the counselor such disclosure is necessary to protect you or someone else from imminent physical or psychological danger. (Please note: In accordance with New York State Law, we are required to report any incidents of child abuse that come to our attention). Information will not be released to an outside agency without your written permission. As professionals, we may confer with each other, the Director of Health & Wellness Services, and the college physician to provide appropriate services.

NY SAFE Act: In January 2013, NY State passed legislation designed to limit a suicidal or homicidal person's access to fire arms. This law required mental health providers to alert the County Director of Community Services and the NY Department of Criminal Justice Services (DCJS) if a person is likely to engage in conduct that will result in serious harm to self or others. THE DCJS will then identify if that person has a gun permit and may remove certain fire arms from their possession in order to protect the identified person or others. This law may also prevent impacted people from obtaining a gun permit for 5 years following a report to the DCJS. The Allegany County Director of Community Services is
Dr. Robert Anderson, PhD., Licensed Psychologist.

Respect: The counselor can be expected to respect you as an individual and convey this respect by keeping appointments or by contacting you if a change in time is necessary, by giving you complete attention during sessions, by avoiding interruptions during sessions, and by providing appropriate counseling.

Concern for Progress: Counselors consider many issues while attempting to provide you with the most effective counseling possible. They concern themselves with how often you meet, what you want to accomplish and the progress being made.

3. Along with your rights as a client, you have certain responsibilities. Your active participation in the counseling process is necessary for progress to be made. Promptness in keeping appointments will allow you to take full advantage of your appointments. Once you have been assigned a regular weekly appointment, it is your responsibility to keep the appointment. If an emergency arises, please cancel your appointment by calling the secretary at the Health & Wellness Services office, 607-587-4200, giving as much advance notice as possible.
4. Sometime after your counseling has been terminated, you may receive a brief evaluation questionnaire from this office. This is routinely done in order to evaluate our services in a constant effort to maintain quality.
5. All counseling is offered free to Alfred State students during the academic terms you are enrolled in classes. Persons who are considering future college study at Alfred State may use the career planning services.
6. If you have any questions regarding the above information, please discuss them with your intake counselor.

7. I have read the above material regarding rights and responsibilities of counseling clients.
8. Your sessions may be audiotaped or videotaped for training purposes. This will not be done without your consent.

Signed: _____ Date: _____

Completing the following information will be helpful to you and your counselor in determining your concerns, setting goals and assessing your progress throughout therapy.

Indicate any problems in the following areas:	**Severity of Problem:** **0- N/A, No Problem** **1- A Little Problem** **2- Moderate Problem** **3- Severing Problem** **4- Disabling**	**Indicate any problems in the following areas:**	
Too much sleep	0 1 2 3 4	Hearing voices when no one is present	0 1 2 3 4
Sleep too little	0 1 2 3 4	Change in appetite	0 1 2 3 4
Interrupted sleep	0 1 2 3 4	Unable to recall periods of time in childhood after age 5	0 1 2 3 4
Nightmares	0 1 2 3 4	Outbursts of anger	0 1 2 3 4
Walking in sleep	0 1 2 3 4	Unable to recall some period of your day	0 1 2 3 4
Memory	0 1 2 3 4	Overwhelming fears	0 1 2 3 4
Concentration	0 1 2 3 4	Racing thoughts	0 1 2 3 4
Attention	0 1 2 3 4	Thoughts that won't go away	0 1 2 3 4
Racial Issues	0 1 2 3 4	Thoughts of harming someone else	0 1 2 3 4
Prejudice	0 1 2 3 4	Thoughts that some person or people are trying to harm you	0 1 2 3 4
Loss of interest in usual activities	0 1 2 3 4	Feelings of hopelessness	0 1 2 3 4
Feelings of sadness	0 1 2 3 4	Sexual concerns	0 1 2 3 4
Loss of energy	0 1 2 3 4	Feelings of sadness	0 1 2 3 4
Feeling tired all the time	0 1 2 3 4	Career choice	0 1 2 3 4
Periods of crying	0 1 2 3 4	Alcohol / drug use	0 1 2 3 4
Feelings of being controlled by forces outside yourself	0 1 2 3 4	Stress	0 1 2 3 4
Feeling compelled to repeat activities for no reason	0 1 2 3 4	Finding employment	0 1 2 3 4
Unable to relax	0 1 2 3 4	Making decisions	0 1 2 3 4

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Indicate any problems in the following areas:	Severity of Problem: 0- N/A, No Problem 1- A Little Problem 2- Moderate Problem 3- Severing Problem 4- Disabling					Indicate any problems in the following areas:					
Excessive sweating	0	1	2	3	4	Friends	0	1	2	3	4
Death of family member or friend	0	1	2	3	4	Assertiveness	0	1	2	3	4
Panic attacks	0	1	2	3	4	Nervousness	0	1	2	3	4
Work issues	0	1	2	3	4	Shyness	0	1	2	3	4
Grades	0	1	2	3	4	Blackouts	0	1	2	3	4
Clarifying personal values	0	1	2	3	4	Problems with partner/spouse	0	1	2	3	4
Alcohol / Drug use	0	1	2	3	4	Roommate	0	1	2	3	4
Self-control	0	1	2	3	4	Self-concept	0	1	2	3	4
Eating behavior	0	1	2	3	4	Motivation	0	1	2	3	4
Guilt	0	1	2	3	4	Loneliness	0	1	2	3	4
Identity	0	1	2	3	4	Finances	0	1	2	3	4
Lifestyle	0	1	2	3	4	Suicidal thoughts	0	1	2	3	4
Abortion	0	1	2	3	4	Separation/Divorce	0	1	2	3	4
Parents	0	1	2	3	4	Health problems	0	1	2	3	4
Selecting a major	0	1	2	3	4	Digestive troubles	0	1	2	3	4
Insomnia	0	1	2	3	4	Panic	0	1	2	3	4
Time Management	0	1	2	3	4	Procrastination	0	1	2	3	4
Appetite	0	1	2	3	4	Headaches	0	1	2	3	4
Pregnancy	0	1	2	3	4	Clarifying personal strengths and weaknesses	0	1	2	3	4
Unhappiness	0	1	2	3	4	Other, specify					
Test anxiety	0	1	2	3	4						

Notes

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Note: The following section is optional. However, completing the following information will help us in continuing to provide students with the best services possible.

I would be interested in learning more about the following services. Please check your answer.

- ☐ Acupuncture
- ☐ Aroma Therapy
- ☐ Biofeedback Training
- ☐ Healthy Choices Program
- ☐ Making Connections Group
- ☐ Massage Therapy
- ☐ Medical Sciences
- ☐ Mind Spa
- ☐ Oasis
- ☐ Psychiatric Services
- ☐ Sleep Trouble Group
- ☐ The Journey to Wellness Programming

Thank you for your feedback