

Welcome to SIUE Counseling Services

Client Information and Informed Consent for Services

Eligibility

Our services are available at no additional cost to all SIUE students presently enrolled in at least three semester hours of credit. If you attend Spring Semester and are enrolled for Fall Semester, you are eligible for services during the Summer Term. To qualify for couple counseling, one partner must be enrolled at SIUE for at least three semester hours of credit.

Length of Services

In general, counseling is limited to one semester (15 sessions) per academic year; however, adjustments may be made as needed. Counseling Services reserves the right to refer clients for counseling elsewhere when the issues of the student are beyond the scope of this center's practice.

Confidentiality

All communication with your counselor, psychologist, or psychiatrist is confidential and will not, except under the circumstances explained below, be disclosed to anyone outside of Counseling Services unless you give written authorization to release information. You will need to sign a Release of Information Form if you wish to have a Counseling Services professional staff communicate information to anyone other than those specified below (see Consent for Limited Release of Information). A record is kept of your work with us. It contains information you have provided us in writing as well as counseling notes of your sessions. The record remains in Counseling Services for a period of seven years following your last visit; at that time, it is destroyed. **Your record never leaves the Counseling Center and never becomes a part of your educational record.**

Limits to Confidentiality

Most limits to confidentiality are to ensure safety. If there is evidence of imminent danger of harm to yourself or other(s), we must take action. If you describe abuse of a child or elder, we must report to the appropriate agency. In addition, a court order may require release of privileged communication.

Retaining Records

Counseling Services will retain your client record for seven (7) years after the date of your last contact with this department, after which it will be destroyed. During that period of time, you may obtain a copy of your record at a standard cost of \$1.00 per page. Please allow one week for your request to be processed. Most likely you will be asked to meet with a counselor to discuss the purpose of the release of records.

Consent for Limited Release of Information

Counseling Services may need to communicate with other SIUE offices on your behalf. Please initial the following if you consent to the exchange of limited with:

- Health Service Initial _____
- Housing Initial _____
- Intercollegiate Athletics Initial _____
- Mandating Official (please specify) _____ Initial _____
- Other (please specify name) _____; attendance only. Initial _____
- Disability Support Services Initial _____
- International Student Services Initial _____
- Dean of Students, Dr. Klenke Initial _____

Please sign a specific Release of Information Form if you wish to have additional information communicated.

SIUE Counseling Services is a clinical training site for Master's-level Counselors and Social Workers graduate students. Your counselor may need to record the counseling sessions for training purposes and quality control purposes **only**.

Client Signature Date

Witness Signature Date

SIUE Counseling Center Client Intake Questionnaire

Date _____

Social Security # _____ Student ID # _____

Name _____
First
Middle
Last

Phone(s): Home _____ Cell _____ E-Mail _____

May we contact you by:

Mail/Letter YES NO
 E-Mail YES NO
 Phone
 Home YES NO Leave a message? YES NO
 Cell YES NO Leave a message? YES NO

Local Residence _____
Residence Hall/Street Address
Room/ Apt. #
City
State
Zip

Mailing Address _____
Residence Hall/Street Address
Room/ Apt. #
City
State
Zip

In an emergency, the Counseling Center has my permission to contact the following (parent, spouse, etc)

Name _____
Last
First
Relationship

Phone _____ Address _____
Street
Apt. #
City
State
Zip

Insurance
 Carrier Name _____ Policy Number _____ Address _____

Academic Status
 _____ Freshman (0-29 hrs.)
 _____ Sophomore (30-59 hrs.)
 _____ Junior (60-89 hrs.)
 _____ Senior (90+ hrs.)
 _____ Graduate Student
 _____ Dental Student
 _____ Post Baccalaureate

Referral Source
 _____ Self Referred
 _____ Friend
 _____ Relative
 _____ Physician _____ Name
 _____ Faculty/Staff _____ Name or Department
 _____ Disciplinary _____ Name

Sexual Orientation (Optional)
 _____ Straight/Heterosexual
 _____ Gay/Homosexual
 _____ Bi/Bisexual
 _____ Not Sure
 _____ Not Disclosed

Date of Birth _____
 Gender Male _____ Female _____

Relationship Status
 _____ Single
 _____ Committed Relationship
 _____ Married/Partnered
 _____ Separated
 _____ Divorced
 _____ Widowed
 _____ Other _____

Are you (Optional)
 _____ US Citizen
 _____ Non-Citizen Resident
 Country of Origin _____
 _____ International Student
 Country of Origin _____

Cumulative GPA _____
 Current Credit Hours _____
 #Hours Employed _____

Current Medications _____

Ethnic/Racial Identification (Optional)
 _____ Black/African American
 _____ Native American/Alaskan Native
 _____ Asian/Asian American/
 Pacific Islander
 _____ Latino(a)/Hispanic
 _____ Caucasian/White American
 _____ Biracial/Multiracial
 _____ Other _____

Living Situation
 _____ Alone
 _____ Roommate(s)
 _____ Partner/Spouse
 _____ Parent(s)
 _____ Children
 _____ Other _____

Employment Status
 _____ Not Employed _____ Employed
 Type of work _____

Expected graduation _____
 Major _____

Transfer NO YES, from _____
 Physical or Learning Disability
 (if applicable) _____

Is this a crisis? YES NO If YES, please explain

Have you used our services before? **YES NO** If **YES**, when, whom did you see, what was the major issue?

Have you had previous counseling or other mental health services? **YES NO** If **YES**, when, where, what was the major issue?

Have you ever seriously considered or attempted suicide? **YES NO** If **YES**, please explain the circumstances.

Do you have any significant medical conditions or significant medical history? **YES NO** If **YES**, please explain.

Do you have any significant legal history or current legal issues pending? **YES NO** If **YES**, please explain.

Are you currently taking any medications? **YES NO** If **YES**, what and for how long?

Please describe your use of alcohol, cigarettes, and recreational drugs.

Describe any events or situations in your childhood that may be affecting your current functioning or situation (e.g. abuse, tornado, death in the family, etc.).

How would you describe yourself?

What would you like to accomplish in counseling? What about your behavior and feelings would you like to change?

Please complete the following:

I am a person who _____

It's hard for me to admit _____

One of the things I can't forgive _____

The thing I feel most guilty about is _____

If I didn't have to worry about my image _____

Some of the ways people hurt me are _____

What I wanted from my father and didn't get was _____

What I wanted from my mother and didn't get was _____

The bad thing about growing up is _____

If I weren't afraid to be myself, I might _____

One of the ways I could help myself, but don't, is _____

Self-Report Checklist

Please rate any issues below that are concerning you by circling the appropriate number (0, 1, 2, 3).

	No Problem	Mild	Moderate	Severe
Schoolwork and grades	0	1	2	3
Procrastination, motivation and time management	0	1	2	3
Academic anxieties (stage fright, speaking, tests)	0	1	2	3
Decision about major/career	0	1	2	3
Adjustment to the University	0	1	2	3
Learning disabilities	0	1	2	3
Finances/money matters	0	1	2	3
Relationships with friends	0	1	2	3
Living situation/roommate	0	1	2	3
Loss/death of significant person	0	1	2	3
Divorce (own, family)	0	1	2	3
Relationship with romantic partner	0	1	2	3
Relationships with family & parents	0	1	2	3
Sexual orientation issues	0	1	2	3
Gender identity issues	0	1	2	3
Sexual decisions/issues	0	1	2	3
Pregnancy/abortion issues	0	1	2	3
Sexually transmitted diseases	0	1	2	3
Childhood sexual abuse/molestation	0	1	2	3
Childhood physical abuse/emotional abuse/neglect	0	1	2	3
Rape/sexual assault	0	1	2	3
Sexual harassment	0	1	2	3
Discrimination/oppression (e.g. racism, sexism, homophobia)	0	1	2	3
Legal matters	0	1	2	3
Religious/spiritual issues	0	1	2	3
Shyness, being assertive	0	1	2	3
Self-esteem, self confidence	0	1	2	3
Loneliness, homesickness	0	1	2	3
Depression	0	1	2	3
Anxiety, fears, worries	0	1	2	3
Irritable, angry, hostile feelings	0	1	2	3
Suicidal feelings/behavior	0	1	2	3
Dealing with physical disability	0	1	2	3
Chronic health problems	0	1	2	3
Physical stress (headaches, stomach pains, muscle tension)	0	1	2	3
Stress	0	1	2	3
ADHD	0	1	2	3
Sleep problems	0	1	2	3
Eating problems	0	1	2	3
Alcohol and/or other drugs (self, family, partner, friend)	0	1	2	3
<i>Other (Please Specify)</i> _____	0	1	2	3

FAMILY/SOCIAL INFORMATION

Describe any family history of mental health problems including alcohol and drug abuse. _____

Parents' current relationship status:

- _____ Married/Partnered
- _____ Separated
- _____ Divorced
- _____ Widowed
- _____ Remarried
- _____ Never Married
- _____ Other

Please provide the following information about members of your family (parents, step-parents, brothers, sisters, step-siblings, partner/spouse, children, other significant relatives)

Name/Relationship	Age	Education	Occupation	How do you get along?
/				
/				
/				
/				
/				
/				
/				
/				
/				
/				

List other people who are important to you (friends, significant other, mentor, etc.)

Name/Relationship	Age	Education	Occupation	How do you get along?

Client Signature _____ Date _____

DEPRESSION SCREENING INVENTORY

Name: _____

Age: _____

Date: _____

Sex: Male Female

Zung Depression Self-Rating Scale

Please check a response for each of the 21 items

	None or little of the time	Some of the time	Good part of the time	Most or all the time
1. I feel downhearted, blue and sad.	_____	_____	_____	_____
2. Morning is when I feel the best.	_____	_____	_____	_____
3. I have crying spells or I feel like it.	_____	_____	_____	_____
4. I have trouble sleeping through the night.	_____	_____	_____	_____
5. I eat as much as I used to.	_____	_____	_____	_____
6. I enjoy looking at, talking to, and being with attractive men/women.	_____	_____	_____	_____
7. I notice that I am losing weight.	_____	_____	_____	_____
8. I have trouble with constipation.	_____	_____	_____	_____
9. My heart beats faster than usual.	_____	_____	_____	_____
10. Get tired for no reason.	_____	_____	_____	_____
11. My mind is as clear as it used to be.	_____	_____	_____	_____
12. I find it easy to do the things I used to.	_____	_____	_____	_____
13. I am restless and can't keep still.	_____	_____	_____	_____
14. I feel hopeful about the future.	_____	_____	_____	_____
15. I am more irritable than usual.	_____	_____	_____	_____
16. I find it easy to make decisions.	_____	_____	_____	_____
17. I feel that I am useful and needed.	_____	_____	_____	_____
18. My life is pretty full.	_____	_____	_____	_____
19. I feel that others would be better off if I were dead.	_____	_____	_____	_____
20. I still enjoy the things I used to do.	_____	_____	_____	_____
21. I am currently thinking of suicide.	_____	_____	_____	_____

AVAILABILITY

CLIENT NAME: _____

Please place an 'X' in the times that best work for you to meet with a therapist. We will do our best to accommodate your needs. After the staff meets on Friday mornings, we will contact you to schedule your first appointment with the therapist assigned to you.

TIME\DAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
8:00 am to 9:00 am					
9:00 am to 10:00 am					
10:00am to 11:00 am					
11:00 am to 12:00 pm					
12:00 pm to 1:00 pm					
1:00 pm to 2:00 pm					
2:00 pm to 3:00 pm					
3:00 pm to 4:00 pm					