Hampden-Sydney College Wellness Center
Client Intake Form

Date ____/____/____

Name _____
Last First Middle

Name you prefer to be called _____

Student ID _____

Date of birth (mm/dd/yyyy) _____

Home Phone _____ OK to phone? ☐Y ☐ N

Cell Phone _____ OK to phone? ☐Y ☐ N

Work Phone _____ OK to phone? ☐Y ☐ N

Email _____
*Provide your e-mail address **ONLY** if you agree to accept e-mails from H-SCWC

Local Address:
Street _____
City _____
State _____ Zip _____

Permanent Address:
Street _____
City _____
State _____ Zip _____

OK to contact at home? ☐Y ☐N

Emergency Contact Name _____
Relationship to you _____
Telephone _____

How did you happen to come to the Hampden-Sydney College Wellness Center (check all that apply)?

- ☐ Self Referred
- ☐ Student Judicial System
- ☐ Academic Advisor
- ☐ Student Health Services
- ☐ Dean of Students
- ☐ Disability Services
- ☐ Faculty
- ☐ Family
- ☐ Friend
- ☐ Previous use of H-SCWC
- ☐ Office of Academic Success
- ☐ Other _____

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Client Information

To serve you better, we need a few facts about the people who visit us. Please provide the information requested. You may omit any item, but by providing all the information requested you can help us do a better job of serving you.

Religious or spiritual affiliation you identify with _____

Gender: ☐ Female ☐ Male

Relationship status: ☐ Single ☐ Married ☐ Dating ☐ Separated

Country of Origin _____

Student Status
☐ Freshman
☐ Sophomore
☐ Junior
☐ Senior
☐ Faculty/Staff

Major _____ Minor _____

Are you currently employed? ☐ Yes ☐ No

Name of employer _____

Number of hours per week you work
☐ Less than 5
☐ 5-10
☐ 10-20
☐ 20-40

Are you currently experiencing a crisis? ☐ Yes ☐ No
If yes, describe the nature of the crisis _____
_____

Select the type(s) of service you are seeking.

☐ Personal/Individual Counseling
☐ Substance Education

Have you seen, or are you currently seeing another counselor or therapist? ☐ Yes ☐ No

If yes, when? _____

For what concerns? _____
Name of counselor/agency: _____
What is your main reason for seeking counseling now? _____
What do you hope to accomplish through counseling? _____

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Please describe your primary parental figures:

Parent #1 Living?
- ☐ Still married or in a domestic partnership
- ☐ Separated
- ☐ Never married
- ☐ Divorced
- ☐ Widow/Widower

Parent #1 Education _____
Parent #1 Occupation _____
Relationship to you _____

Parent #2 Living?
- ☐ Still married or in a domestic partnership
- ☐ Separated
- ☐ Never married
- ☐ Divorced
- ☐ Widow/Widower

Parent #2 Education _____
Parent #2 Occupation _____
Relationship to you _____

How satisfied are you with your academic progress so far?
☐ Very satisfied ☐ Satisfied ☐ Neutral ☐ Dissatisfied ☐ Very dissatisfied

What barriers, if any, are impeding your academic progress? _____
_____

What are your long-term education and vocational goals? _____
_____

What are other long-term goals in your life? _____
_____

Please list any disability, medical condition, or physical symptoms you would like your counselor to know about _____

Prescription medications you are currently taking (including birth control pills, allergy medications, dosages, etc)_____
_____

Following are two checklists and the consent to treatment and confidentiality form. If you would like to receive personal/individual counseling, complete the personal concerns checklist. If you would like to receive substance education counseling, please complete the substance concerns checklist. Please read the consent to treatment and confidentiality form, sign and date it.

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Personal Concerns Checklist

If you would like to receive personal/individual counseling, please complete the following checklist. If you would NOT like to receive personal/individual counseling, skip this checklist and complete the Substance Concerns checklist.

- ☐ Depression
- ☐ Anxiety
- ☐ Poor concentration
- ☐ Lonely, do not feel connected
- ☐ Lack of self-confidence
- ☐ Irritable, angry
- ☐ Difficulty making decisions
- ☐ Feeling sad or blue
- ☐ Having problems with sleep
- ☐ Lack meaning in my life
- ☐ Problems with eating or food
- ☐ Concerned about my health
- ☐ Concern about AIDS/HIV or other sexually transmitted infections (STI's)
- ☐ Concerned about financial problems
- ☐ Find it difficult to express my feelings, stand up for myself
- ☐ Concerns about relationship with my partner
- ☐ Having difficulty with friends
- ☐ Concerned about relationships with parents and siblings
- ☐ Concerned about sex or sexual relationships
- ☐ Discrimination/Hate crime
- ☐ Concerned about my sexual or gender identity
- ☐ Spiritual concerns
- ☐ Racial, cultural, or ethnic concerns
- ☐ Loss/death of a significant person
- ☐ Harassment/Stalking
- ☐ Feeling overwhelmed/stressed
- ☐ Bothered by troublesome thoughts
- ☐ Physical or emotional abuse
- ☐ Sexual assault, past or current sexual abuse
- ☐ Thoughts of harming myself or another person
- ☐ Have deliberately injured myself

Other: _____

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Substance Education Concerns

If you would like to receive substance education counseling, please complete the substance concerns checklist.

Please indicate your substance use history and circle the frequency of use.

☐ Alcohol
- Never Occasionally Frequently Daily

☐ Marijuana
- Never Occasionally Frequently Daily

☐ Cocaine
- Never Occasionally Frequently Daily

☐ LSD
- Never Occasionally Frequently Daily

☐ Sedatives
- Never Occasionally Frequently Daily

☐ Stimulants
- Never Occasionally Frequently Daily

☐ Opiates
- Never Occasionally Frequently Daily

☐ Designer Drugs
- Never Occasionally Frequently Daily

☐ Other_____
- Never Occasionally Frequently Daily

Are you taking any vitamins, supplements or over the counter medications? ☐ Y ☐ N

If so, please list _____

Do you have any family members that have struggled with substance abuse/addiction? ☐ Y ☐ N

If so, please explain _____
_____

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CONSENT TO TREATMENT

By signing below, I consent to treatment by the Wellness Center Staff. I understand that Counseling Services values the privacy of its clients and the confidentiality of the personal and health information entrusted to us. In order to protect this privacy, we have policies and procedures to limit disclosures of personal information to those minimally necessary for the medical care of the client, those for which the client has given permission, and/or those required by law or public safety.

Section A – Policies and Procedures of Confidentiality:

1. **Maintaining privacy –** Counseling Services is required by law to maintain the privacy of protected counseling information and to provide and abide by this notice of its legal duties and privacy practices.
2. **Treatment –** Counseling information may need to be shared with Counseling Services counselors, psychologists, and staff psychiatrists as well as physicians, nurses, and other allied health professionals in Student Health Services in order to provide effective and efficient care.
3. **Public health and safety –** Personal counseling and health information may be disclosed to the proper authorities to report intent to harm self or others, deaths, certain infectious diseases, occupational injuries and diseases, child or incapacitated adult abuse/neglect, problems with medications and other products as required by law to prevent/control disease, injury or disability to the client or to others.
4. **Legal requirements –** Counseling information may be disclosed as required by court or administrative order, subpoena, discovery request, or other lawful processes.
5. **Other uses** – Uses and disclosures of health and personal information other than described above will be made only with the client's (your) written authorization. Such authorization when given may be revoked in writing by the client (you) at any time.

Section B – The client also has certain rights. These include:

1. **The right to inspect and obtain copies of counseling records** – Any such requests must be made in writing by the client utilizing the Counseling Services authorization for release of information form or in the case of information to be released to another health care provider the form provided by that provider. Counseling Services may deny, in writing, the release or viewing of personal counseling information if the Administration of the Counseling Services department determines that the release of the information may be harmful to the client or another person. When such a request is denied, the client may request, in writing, a review of the denial.
2. **The right to request limits on the amount or types of counseling information released** – Such requests must be made in writing. Counseling Services may not agree with this request when it is felt to be in the client's best interest to release the information and/or when such a release is mandated by the procedures and policies outlined above.

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CONSENT TO TREATMENT

I have read and understand the conditions of confidentiality.

_____ _____

Signature Date

If your parent contacts the Wellness Center asking for information about your treatment, do you consent to the release of any information?

☐ Yes ☐ No

_____ _____

Signature Date

I acknowledge that if I am referred by the Student Judicial System that a report of my participation in treatment will be released to the Judicial Council and Dean of Students office.

_____ _____

Signature Date