

Intake Questionnaire

Today's Date Full Name Cougar ID

Primary Phone May we call you at this number (Y/N)? Date of Birth Age

Local Address City State Zip

Emergency Contact Name Relationship Phone Number

What is your gender identity? Woman Man Transgender Self-Identify:

What is your race/ethnicity? African American/Black American Indian/Alaskan Native Asian American/Asian
Hispanic/Latinx Native Hawaiian or Pacific Islander Multi-racial
White Other:

Are you a veteran or currently enlisted in the military? Yes No
If yes, list military branch:

Do you have insurance? Yes No
If yes, list provider: Policy holder name:

Were you referred here? Yes No If yes, reason for referral:
Person making referral: Telephone:

Current Academic Status:
High school student taking college classes Non-degree student Faculty or staff
First Year Second Year Third Year Fourth+ Year
Postgraduate Student Other:

Are the problems you want to address in counseling interfering with your academic performance?
Yes No

Please state why you have decided to pursue counseling services now:

How would you rate the severity of the problem at this time? (Place an "x" on the line below)

Mild Moderate Serious Severe

What would you like to learn that could help you with the problem? (Check all that apply)
Learn what is creating my problems
Learn more about myself
Learn how to feel better
Learn how to respond differently to problems, issues, etc.
Learn how to cope with feelings/situations
I have no idea
Other:

**What concerns/symptoms contributed to you coming in today? Please check all that apply.**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Academic concerns   | <input type="checkbox"/> Self-harm behaviors (cutting, burning, etc.) | <input type="checkbox"/> Numbness/lack of emotion  |
| <input type="checkbox"/> Adjustment to the college                                 | <input type="checkbox"/> Suicidal thoughts                            | <input type="checkbox"/> Procrastination/lack of motivation  |
| <input type="checkbox"/> Worry about how much I drink                              | <input type="checkbox"/> Recent break up of romantic relationship     | <input type="checkbox"/> Racial/ethnic identity  |
| <input type="checkbox"/> Worry about drug use                                      | <input type="checkbox"/> Thoughts of wanting to harm another person   | <input type="checkbox"/> People, objects, or the world around me seem strange or unreal                |
| <input type="checkbox"/> Anxiety/worry   | <input type="checkbox"/> Gender identity                              | <input type="checkbox"/> Problem in relationship with a romantic partner                               |
| <input type="checkbox"/> Career concerns   | <input type="checkbox"/> Concerns about sexuality                     | <input type="checkbox"/> Problem in relationship with parents/family                                   |
| <input type="checkbox"/> Depressed mood  | <input type="checkbox"/> Hearing or seeing things that others cannot  | <input type="checkbox"/> Sexual concerns (pain during intercourse, erectile dysfunction, libido, etc.) |
| <input type="checkbox"/> Difficulty making friends                                 | <input type="checkbox"/> Housing concerns                             | <input type="checkbox"/> Shyness/being assertive   |
| <input type="checkbox"/> Experiencing a traumatic event                            | <input type="checkbox"/> Inability to control thoughts                | <input type="checkbox"/> Spiritual/religious concerns  |
| <input type="checkbox"/> Experiencing discrimination                               | <input type="checkbox"/> Irritable, angry, hostile feelings           | <input type="checkbox"/> Test anxiety or speech anxiety  |
| <input type="checkbox"/> Fear of specific places/objects                           | <input type="checkbox"/> Issues with food/weight/appetite             | <input type="checkbox"/> Other _____   |
| <input type="checkbox"/> Financial concerns  | <input type="checkbox"/> Loss of a significant person                 |  |
| <input type="checkbox"/> Feeling as though I am looking at the world through a fog | <input type="checkbox"/> Loneliness                                   |  |
| <input type="checkbox"/> Self-esteem/self-confidence                               |   |  |

**Have you ever had treatment by a psychiatrist, psychologist, therapist, or counselor? \_\_\_ Yes \_\_\_ No**

If yes, please note the following:

Presenting Problem	When (dates)	Was it helpful? (Y/N)
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Presenting Problem	When (dates)	Was it helpful? (Y/N)
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**Are you currently in treatment with a therapist or counselor? \_\_\_ Yes \_\_\_ No**

If so, please explain: \_\_\_\_\_

**Please list any significant past/present illnesses or injuries impacting your mental health:**

Problem & Treatment	Dates	Hospitalization (Y/N)
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Problem & Treatment	Dates	Hospitalization (Y/N)
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**Have you ever taken any psychiatric medications? \_\_\_ Yes \_\_\_ No**

**Please list ALL current medications/supplements you are taking:**

Medication/Supplement	Reason for Taking	Helpful (Y/N)

**Think back to the last two weeks. How many times have you had five or more drinks\* in a row (for males) or four or more drinks\* in a row (for females)?**

(\*A drink is a bottle of beer, a glass of wine, a wine cooler, a shot glass of liquor, or a mixed drink.)

\_\_Never    \_\_Once    \_\_Twice    \_\_3 to 5 times    \_\_6 to 9 times    \_\_10 or more times

**Think back over the last two weeks. How many times have you smoked marijuana?**

\_\_Never    \_\_Once    \_\_Twice    \_\_3 to 5 times    \_\_6 to 9 times    \_\_10 or more times

**Think back over the last two weeks. How many times have you abused prescription drugs (taking drugs in a way that was not recommended by your doctor)?**

\_\_Never    \_\_Once    \_\_Twice    \_\_3 to 5 times    \_\_6 to 9 times    \_\_10 or more times

**Think back over the last two weeks, how many times have you abused non-prescription drugs (drugs that were not prescribed by your doctor and taken against medical necessity)?**

\_\_Never    \_\_Once    \_\_Twice    \_\_3 to 5 times    \_\_6 to 9 times    \_\_10 or more times

**How many times have you tried heroin in your lifetime?**

\_\_Never    \_\_Once    \_\_Twice    \_\_3 to 5 times    \_\_6 to 9 times    \_\_10 or more times

**Think back to the last two weeks. How many times have you used heroin?**

\_\_Never    \_\_Once    \_\_Twice    \_\_3 to 5 times    \_\_6 to 9 times    \_\_10 or more times

**Please check any drugs or categories of drugs that you have tried or experimented with:**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Cocaine  | <input type="checkbox"/> Percocet, Vicodin, OxyContin                     | <input type="checkbox"/> Tobacco (e.g. cigarettes, cigars etc.) |
| <input type="checkbox"/> Adderall (not prescribed)                            | <input type="checkbox"/> Methamphetamines                                 | <input type="checkbox"/> Diet Pills                             |
| <input type="checkbox"/> Other Hallucinogens                                  | <input type="checkbox"/> Mushrooms  | <input type="checkbox"/> Xanax                                  |
| <input type="checkbox"/> Crack  | <input type="checkbox"/> Methadone  | <input type="checkbox"/> Benzodiazepines                        |
| <input type="checkbox"/> Speed  | <input type="checkbox"/> K-2  | <input type="checkbox"/> Sedatives                              |
| <input type="checkbox"/> Inhalants (e.g. gasoline, glue, paint thinner, etc.) | <input type="checkbox"/> Bath Salts                                       | <input type="checkbox"/> Ecstasy                                |
| <input type="checkbox"/> Amphetamines   | <input type="checkbox"/> Suboxone   | <input type="checkbox"/> Club Drugs                             |
| <input type="checkbox"/> Acid   | <input type="checkbox"/> Caffeine (e.g. coffee, energy drinks, tea, etc.) | <input type="checkbox"/> Salvia                                 |

**Have you received drug and/or alcohol counseling in the past?    \_\_Yes    \_\_No**

If so, please list the name of the providers where you received treatment.

_____	_____	_____	_____
Name	Dates	City	Was treatment helpful? (Y/N)

_____	_____	_____	_____
Name	Dates	City	Was treatment helpful? (Y/N)

**COMPLETE OTHER SIDE**



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### **Appointment Cancellation Agreement**

We understand that unplanned circumstances can occur and you may need to cancel an appointment. If that happens, we respectfully ask that you call our office at 614-287-2818, 24 hours in advance to cancel your appointment so that others who also need services can be scheduled.

#### **Cancellations**

- *If you cancel an appointment within 24 hours, you may reschedule with our Office Associate at any time.*
- *If you have two consecutive cancellations, you will need to speak with your therapist prior to rescheduling.*

#### **No Call/No Show**

- *If you have scheduled an appointment and no call/no show, the missed appointment will count towards the allotted number of counseling sessions.*
- *After your first No Call/No Show a courtesy email will be sent to your **STUDENT EMAIL** reminding you of the cancellation agreement. Our message to you will hold the same privacy as any other messages on your Cougar E-mail service. If you do not know your student email or password, please contact Technical Support @ 614.287.5050 or go to Columbus Hall for assistance.*
- *After two consecutive No Call/No Shows you will need to speak with your therapist about ongoing treatment as well as external mental health or alcohol and other drug treatment services.*

Thank you for your understanding and cooperation of our Cancellation Agreement. This agreement will enable us to better serve the needs of all students.

\_\_\_\_\_  
Student Name (print)

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

## **Client Rights and Services Information**

Columbus State is pleased to provide you with short-term counseling and referral services while you are enrolled at this institution.

As a student receiving counseling, it is important that we provide you with information about services, confidentiality, and our office procedure. As professionals, we are trained to help individuals with academic, emotional, psychological, social, and behavioral problems. It is our basic purpose to help students cope with, or resolve, problems that create distress in daily living and are interfering with academic success at Columbus State. We usually accomplish this by (1) increasing your personal awareness, (2) setting a short-term goal that addresses your presenting problem, and (3) working with you to make appropriate changes that enable you to succeed in your studies.

The effect of services is difficult to predict. Some people who receive counseling feel better, some feel worse off, and some feel about the same at the end of their treatment. We hope that you will be better off of course, however we cannot predict the outcome of your experience in counseling.

The information you discuss is confidential between you and your mental health provider and his/her supervisor, or other appropriate Columbus State personnel. Please feel free to discuss this issue with your mental health provider or his/her supervisor. We will not release any information to any party without your written consent, within the limits of the law. There are some exceptions to confidentiality of which you need to be aware. These include: suspected abuse or neglect of children or vulnerable adults, situations involving potential suicide or homicide, or mental health provider records in legal proceedings relative to misconduct allegations.

All services in the Counseling Services Department are free of charge to Columbus State students. The length of treatment consists of short-term services. If it is determined that long-term mental health counseling services are more appropriate to address your clinical need(s), your mental health professional will work with you to provide a referral to a qualified mental health professional in the community, if you choose to continue seeking mental health counseling. If you are referred to a qualified mental health professional in the community, you may be charged for services by the agency you choose to go to for services. Overall, your mental health professional at Columbus State will be happy to assist you in finding an appropriate referral to address your needs.

It is your right to discontinue treatment any time you feel it is in your best interest to do so. It is the mental health provider's ethical responsibility to end the relationship when it is clear that the student is not benefiting from services. In that situation you will then be asked if you would like to have assistance for a referral elsewhere for continued services. If you decide to end services, we request that you first discuss this important issue with your mental health professional at Columbus State.

All mental health treatment records remain the property of Columbus State. Clients (i.e., students) request access to their own mental health treatment records, in writing, to their mental health professional or appropriate supervisor. Reasonable access shall be provided.

Qualified mental health professionals who are concerned that a clients' access to their records could cause serious misunderstanding or harm to the client shall provide assistance in interpreting the records and consultation with the client regarding the records (Chapter 4757-5-09).

In case of an emergency, including intentional harm to yourself or others, you are advised to call 911 for immediate assistance. You may also call the Columbus State Police Department at 287- 2525.

We want to provide the best possible services to our students. It is the established policy of Columbus State Community College not to discriminate against any individual or group of individuals for reason of race, color, religion, ancestry, national origin, age, gender, sexual orientation, gender identity and expression, disability or veteran status. Please feel free to ask your mental health professional about any questions you may have regarding your involvement in mental health services at Columbus State.

**BEFORE SIGNING BELOW, PLEASE FEEL FREE TO ASK ANY QUESTIONS ABOUT THE INFORMATION ABOVE. A COPY WILL BE PROVIDED TO YOU UPON REQUEST.**

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*I have discussed the nature, scope, and limitations of services that my mental health provider will be able to provide for me. I have received, read, and understand all of the above. I have also received a copy of the Columbus State HIPAA Notice of Privacy Practices, regarding confidential health information.*

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Student's name (Please print)

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Student's signature

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Date

---

Witness

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Date

## HIPAA and FERPA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

**Explanation of Forms.** This Notice of Privacy Practices describes how Columbus State Community College Counseling Services may use and disclose your protected health information to carry out treatment or conduct health care operations and for other purposes that are permitted or required by law. Columbus State Community College reserves the right to make changes in this Notice of Privacy Practices. The Notice describes your rights to access and control of your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

**Types of Uses and Disclosures.** Medical Information about you may be used by Columbus State Community College Counseling Services for treatment and health care operations. Treatment includes consultation, assessment, diagnosis, provision of care, and referrals. Health care operations include procedures Columbus State Community College Counseling Services does to assess quality of care, train staff, and manage Columbus State Community College Counseling Services business. Some examples of disclosures and use are as follows:

1) **Treatment Disclosure.** Columbus State Community College Counseling Services may disclose clinical information about you to your treating physician, a hospital or other providers to help them diagnose and treat an injury or illness.

2) **Health Care Operations Use.** Columbus State Community College Counseling Services may use clinical information about you when it hires new staff whose training requires information about the medical needs of our clients.

Columbus State Community College Counseling Services will not disclose information about you without an authorization except as required by law. Columbus State Community College Counseling Services may also contact you to provide appointment reminders or cancellations. We may leave this limited information via email or voicemail at the telephone or fax numbers provided by you unless you request a restriction regarding this method of communicating your protected health information.

**Other Uses and Disclosures.** We may use or disclose your protected health information in the following situations without your authorization. These situations include:

**As Required By Law.** We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law.

**Public Health.** We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information to another government agency that is collaborating with the public health authority.

**Health Oversight.** We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

**Abuse or Neglect.** We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information.

**Legal Proceedings.** We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

**Law Enforcement.** We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of Columbus State Community College Counseling Services, and (6) medical emergency (not on Columbus State Community College Counseling Services premises) and it is likely that a crime has occurred.

**Criminal Activity.** Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

**Research.** We may disclose certain elements of your protected health information to researchers when the research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

**Military Activity and National Security.** When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military service. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

**Workers' Compensation.** Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally established programs.

**Required Uses and Disclosures.** Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the law.

**Others Involved In Your Healthcare.** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

**Authorized Uses and Disclosures.** Additional uses and disclosure may be made if you have given written authorization, which may be revoked at any time in writing delivered to the Director of Counseling Services, except to the extent Columbus State Community College Counseling Services acted in reliance on the authorization.

**Restrictions.** You have the right to request restrictions on the use and disclosure of medical information about you. However, Columbus State Community College Counseling Services will only be bound by the restrictions if Columbus State Community College Counseling Services notifies you that it agrees with them.

**Confidentiality.** You have the right to have Columbus State Community College Counseling Services use only confidential means of communicating with you about medical information. This means you may have information delivered to you at a certain time or place, or in a manner that keeps your information confidential.

**Access.** You have the right to see and receive a copy of information about you kept by Columbus State Community College Counseling Services under most circumstances.

**Amendment.** You have the right to have Columbus State Community College Counseling Services amend its records of information about you. Columbus State Community College Counseling Services may refuse to amend information that is accurate, that was created by someone else, or is not disclosable to you.

**Accounting.** You have the right to see a list of certain disclosures of medical information about you by Columbus State Community College Counseling Services, which includes the purposes and recipients of the information.

**Copy.** You have the right to receive a paper copy of this notice.

**Privacy Notice.** Columbus State Community College Counseling Services is required by law to keep clinical information about you private and to give you this notice.

Columbus State Community College Counseling Services must abide by this notice. However, Columbus State Community College Counseling Services reserves the right to amend this notice and make such change applicable to all clinical information maintained by Columbus State Community College Counseling Services. Columbus State Community College Counseling Services will provide a revised notice to clients by posting the new notice in the waiting room of the Counseling Services and on our website.

**Complaints.** You may complain to Columbus State Community College Counseling Services if you believe your privacy rights have been violated by giving a written complaint to the Director of Counseling Services at Columbus State Community College. You may also complain to the Secretary of the U.S. Department of Health and Human Services. Columbus State Community College Counseling Services will not retaliate against you for making a complaint.

**Effective Date.** This notice is effective from July 31, 2014 until revised by Columbus State Community College Counseling Services.

Student Name (Please print): \_\_\_\_\_ Date: \_\_\_\_\_

Student Name (Signature) \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_