COLUMBUS STATE
COUNSELING SERVICES

Intake Questionnaire

Nestor Hall Room 010
550 E. Spring Street, Columbus OH 43215
Telephone (614) 287-2818
Fax (614) 287-6324

_____ _____ _____
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:_____

COMPLETE OTHER SIDE 

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

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

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)

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)

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:

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

COMPLETE OTHER SIDE 

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Counseling Services
Nestor Hall, Room 010
P.O. Box 1609
Columbus, Ohio 43216-1609
614-287-2818

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

Revised 7/2014

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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.

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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.

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.

_____
Student's name (Please print)

_____ _____
Student's signature Date

_____ _____
Witness Date

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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 Slate 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 Stale Community College Counseling Services does to assess quality of care, train staff, and manage Columbus Stale Community College Counseling Services business. Some examples of disclosures and use are as follows:

I) *Treatment Disclosure.* Columbus Slate 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 Slate 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 hearth 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.

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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:_____

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Authorization for Release of Information

I, (*student name*):_____SS#_____DOB_____
hereby grant, Columbus State Community College permission to:
_____Release to:
_____Request from: _____
Full Name, Title, Institution or Agency

_____
Address

_____
City State ZIP

_____
Phone Fax

The following information (Check √ all that apply):

_____Intake Assessment
_____Medication Flow Sheet
_____Psychiatric Evaluation
_____Psychiatric Progress Notes
_____Academic Progress/Status
_____Alcohol and/or Drug History
_____Termination Summary
_____Individualized Plan/Diagnosis
_____Other:_____

For the specific purpose of (Check √ all that apply):

_____Application for Eligibility
_____Assist in Educational Planning
_____Develop Appropriate Referral Resources
_____Develop Appropriate Support Services
_____Continuity and/or coordination of care
_____Facilitate legal representation regarding (must complete) _____
_____Work Release
_____Other: _____

This authorization is effective for medical records from_____(date) through_____(date)
I understand that this authorization will automatically expire 180 days after the date on the release, unless otherwise indicated. If the student is part of an approved research study, or is expected to receive services for an extended period of time, this release may be extended up to 180 days.

Expiration /Extension Date: _____

I understand that the records I have authorized to be released may contain confidential information, including, but not limited to psychiatric diagnosis and treatment, alcohol or drug abuse, HIV test results or other communicable diseases. I further understand that this information will be released as it appears in the records unless I specify exceptions and exclusions below: _____ I understand that the information disclosed is protected by law and may not be disclosed without my written authorization or as otherwise authorized by law; however I understand that Columbus State Community College cannot control the recipient's use of the information. I also understand that I may revoke this consent at any time except to the extent that action had been taken in reliance on it.

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Prohibition against Re-Disclosure:
This information has been disclosed to you from records protected by Federal Confidentiality rules (42 CFR Part 2). The Federal Rules *prohibit you from making any further disclosure of this information* unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or is otherwise permitted by 42 CFR Part 2 and/or 34CFR Part 99. A general authorization for release of medical (or other information) is *not sufficient* for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

This consent is subject to revocation at any time except to the extent that action has already been taken in reliance upon such consent. If not previously revoked, this consent will terminate on_____.

_____
Student Name (Please Print)

_____ _____
Student Name (Signature) Date

_____ _____
Witness Date

Revised 7/2014