

ABILENE CHRISTIAN UNIVERSITY UNIVERSITY COUNSELING CENTER

Semester: Fall Spring Summer Maymester

Date: _____

PERSONAL INFORMATION

Banner ID: _____

Print Full Name: _____
First Middle Last

We may need to contact you to confirm an appointment time, reschedule an appointment or follow-up with you; please indicate how you prefer to be contacted: (check all that apply)

Local Phone: _____ Ok? Cell: _____ Ok? Email: _____ Ok?

Date of Birth: _____ Age: _____ Gender: Female Male

Local Address: _____ City/State: _____ Zip: _____

Permanent Address: _____ City/State: _____ Zip: _____

Ethnicity: Please further describe your racial, cultural, ethnic or regional identity.

<input type="checkbox"/> African American/Black	<input type="checkbox"/> Hispanic/Latino
<input type="checkbox"/> American Indian/Native Alaskan	<input type="checkbox"/> Native Hawaiian/Pacific Islander
<input type="checkbox"/> Asian American/Asian	<input type="checkbox"/> Multi-racial
<input type="checkbox"/> Caucasian/White	<input type="checkbox"/> Other _____

Are you an international student? Yes No If so, please list County of Origin _____

Relationship Status: Single Separated
 Seriously Dating/Committed Relationship Divorced
 Married Widowed
 Single Parent

Class: FR SO JR Full Time: Part Time:
 SR BAS GRAD Current GPA: _____

Major: _____ Department: _____

Did you transfer from another campus/institution to this school? Yes No What year? _____

Are you registered, with the office for disability services on this campus, as having a documented and diagnosed disability? Yes No

If you selected, "Yes", for the previous question, please indicate which category of disability you are registered for. (Check all that apply).

<input type="checkbox"/> Attention Deficit/Hyperactivity Disorders	<input type="checkbox"/> Physical/Health Related Disorders
<input type="checkbox"/> Deaf or Hard of Hearing	<input type="checkbox"/> Psychological Disorder/Condition
<input type="checkbox"/> Learning Disorders	<input type="checkbox"/> Visual Impairments
<input type="checkbox"/> Mobility Impairments	<input type="checkbox"/> Other _____
<input type="checkbox"/> Neurological Disorders	

What kind of housing do you currently have? On-campus Off-campus

With whom do you live? Alone Spouse, partner or significant other Roommates Children Parent(s) or Guardian(s) Family Other _____

Do you participate on an athletic team that competes with other colleges or universities? Yes No

Please indicate your level of involvement in organized extra-curricular activities (e.g., sports, clubs, student government, etc.) None Occasional participation 1 regularly attended activity 2 regularly attended activities 3 or more regularly attended activities

Please estimate the number of hours per week you are actively involved in extra-curricular activities. _____

What is the average number of hours you work per week during the school year (paid employment only)? _____

Have you ever been enlisted in any branch of the US military (active duty, veteran, national guard or reserves)? Yes No Branch _____

Did your military experience include any traumatic or highly stressful experiences which continue to bother you? Yes No

If yes, please describe:

Are you the first generation in your family to attend college? Yes No

How would you describe your financial situation right now? Always stressful Sometimes stressful Often stressful Rarely stressful

How would you describe your financial situation while growing up? Always stressful Sometimes stressful Often stressful Rarely stressful

Religious or spiritual preference Agnostic Atheist Buddhist Catholic Christian Hindu Jewish Muslim No preference Other _____

To what extent does your religious or spiritual preference play an important role in your life? Very Important Important Neutral Unimportant Very Unimportant

Over the last two weeks. How many times have you had: 5 or more drinks* in a row (for males) OR 4 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.)

None Once Twice 3 – 5 times 6-9 times 10 or more times

Have you . . .	Never	Prior to College	After starting college	Both	
Attended counseling for mental health concerns?					
Taken a prescribed medicine for mental health concerns?					
Been hospitalized for mental health concerns?					
Felt the need to reduce your alcohol or drug use?					
Have others expressed their concern about your alcohol or drug use?					
Received treatment for alcohol or drug use?					
Purposely injured yourself without suicidal intent?					
Seriously considered attempting suicide?					
Made a suicide attempt?					
Considered seriously injuring another person?					
Intentionally caused serious injury to another person?					
Had unwanted sexual contact(s) or experience(s)?					
Experienced harassing, controlling and/or abusive behavior from another person? (e.g., friend, family member, partner or authority figure)					
Experienced a traumatic event that caused you to feel intense fear, helplessness or horror?					
If you selected a positive response to the previous question, please briefly describe the event(s):					
Please select the traumatic event(s) you have experienced, witnessed or learned about:					
<input type="checkbox"/> Childhood physical abuse <input type="checkbox"/> Childhood sexual abuse <input type="checkbox"/> Childhood emotional abuse <input type="checkbox"/> Physical attack (e.g., mugged, beaten up, shot, stabbed, threatened with a weapon) <input type="checkbox"/> Sexual violence (rape or attempted rape, sexually assaulted, stalked, abused by intimate partner, etc.) <input type="checkbox"/> Military combat or war zone experience <input type="checkbox"/> Kidnapped or taken hostage <input type="checkbox"/> Serious accident, fire, or explosion (e.g., an industrial, farm, car, plane or boating accident) <input type="checkbox"/> Terrorist attack <input type="checkbox"/> Near drowning <input type="checkbox"/> Diagnosed with life threatening illness <input type="checkbox"/> Natural disaster (e.g., flood, earthquake, hurricane, etc.) <input type="checkbox"/> Imprisonment or Torture <input type="checkbox"/> Animal attack <input type="checkbox"/> Witnessed the serious injury or unnatural death of a person due to an accident, war or disaster <input type="checkbox"/> Unexpectedly witnessed a dead body or body part <input type="checkbox"/> Learned that one's child or close loved one has a life threatening disease <input type="checkbox"/> Learned about the violent personal assault, serious accident or serious injury of a close family member or friend <input type="checkbox"/> Learned about the sudden unexpected death of a very close family member or friend <input type="checkbox"/> Other _____					
Please indicate how much you agree with each of these statements.	Strongly disagree	Somewhat disagree	Neutral	Somewhat agree	Strongly agree
I get the emotional help and support I need from my family.					
I get the emotional help and support I need from my social network (e.g., friends and acquaintances).					

SCHEDULE APPOINTMENT

Instructions: Please shade in the day and times you *are* available for counseling.

	Monday	Tuesday	Wednesday	Thursday	Friday
8:00					
8:30					
9:00					
9:30					
10:00					
10:30					
11:00					
11:30					
12:00					
12:30					
1:00					
1:30					
2:00					
2:30					
3:00					
3:30					
4:00					

CLIENT STATUS

New Client

Previous Client I *do* *do not* want to continue working with my previous therapist.

Previous Therapist's Name

ACU EMPLOYEE

Faculty Faculty Dependent of

Staff Staff Dependent of

CONTACT FOR APPOINTMENT:

**We will need to contact you to confirm an appointment time; please indicate how we may do this if you are not available when we call: (check all that apply)*

- | | |
|---|---|
| <input type="checkbox"/> Leave appointment time on answering machine. | <input type="checkbox"/> Leave callback number for a message. |
| <input type="checkbox"/> Leave appointment time with roommate or other. | <input type="checkbox"/> E-mail appointment information. |

(OFFICE USE)

Appointment Scheduled: _____ **Therapist:** _____

Day of Week _____ **Date** _____ **Time** _____

Date Message Left	Type of Message (phone/email)	Comments

**Abilene Christian University
University Counseling Center
Client Information and Informed Consent for Treatment**

Confidentiality:

Perhaps the most critical factor in a therapeutic relationship is confidentiality. Much of what you may wish to share with your therapist is very personal. We, as health care professionals, join with the administration of this university in affirming your right to privacy. Information shared during a counseling session can only be shared with an appropriate outside party(s) if one or more of these criteria are met:

1. You sign a written release of information permitting such disclosure.
2. Supervisory purposes - if your therapist is a sub-doctoral level staff member or trainee. (Note: Supervision is always provided by a licensed mental health professional via chart notes, tests, video and/or audiotape).
3. You are assessed as being potentially harmful to yourself or others.
4. You are assessed as being emotionally disturbed to the point of being unable to care for yourself.
5. You reveal current information about abuse or neglect of minors or the elderly.
6. Records are ordered by a court of law.
7. A summary of records is requested by your insurance company or managed care company.
8. You have medical or health related issues that warrant consultation with the ACU physician or nursing staff, in order to assist us with a holistic and comprehensive approach to your treatment.

Scheduling Appointments:

Initial appointments can be scheduled by coming by our office in McKinzie Hall, lower level, East end. Efforts are made to schedule new clients within 48 hours of their requests for services. The clinic director reviews each file and selects the therapist with expertise and an appointment slot that are the best fit for you. Follow-up sessions will be scheduled through your therapist. Former clients wishing to return for further treatment may request their former therapist, and will be worked into his/her schedule as quickly as possible. Since our Center serves as a training site for Master-degree candidates in the psychology and MFI departments, you may be assigned to a practicum student. All graduate students are regularly supervised. Video and audiotapes are kept in strictest confidence and are destroyed at the end of each semester. If, at any time, you become dissatisfied with the services you are receiving or desire to change a therapist, please discuss these concerns with your therapist; we will try to accommodate you.

Canceling Appointments:

Our demand for services is so great that we have a waiting list. Please consider those people waiting for services when you think about not showing up for an appointment. We would like (at least) 24 hours notice (whenever possible) if you need to cancel or reschedule. You may leave a message with the secretary or on voice mail at 674-2626 if your therapist is not available or if the phone lines are busy. This will give us time to schedule someone else in your time slot.

Client Fees:

There will be a \$10.00 user fee per visit for ALL clients. Payment is due at time of service. You will be expected to sign a billing document that allows us to bill your account for \$10.00 if you do not pay cash on the day of services. If you choose to bill your account it will show up as a consultation fee on your ACU Bill.

We are pleased to offer the highest quality of mental health services to you. In exchange, we expect and appreciate your cooperation with the above outlined procedures.

Steve Rowlands, MMFT, LMFT, LPC
Director of the Counseling Center

I have read and agree to abide by the policies and procedures outlined in this document. I understand the terms and limits of confidential information shared with my therapist. By signing this I do hereby consent to treatment and agree to make payments as outlined above.

Client's Signature (in pen) _____ Date _____

Therapist's Signature (in pen) _____ Date _____

**ABILENE CHRISTIAN UNIVERSITY
UNIVERSITY COUNSELING CENTER
LIFE HISTORY QUESTIONNAIRE**

I. GENERAL INFORMATION

Full Name _____ Today's Date: _____
 Last First Middle

Who suggested you contact us? _____

II. HEALTH

1. Briefly describe your reason for seeking help. _____

2. Describe previous counseling or treatment you received for mental health or family/social problems (list dates seen, names & addresses of therapist, minister, etc.) _____

3. Please comment on any member of your family who suffers from a mental health problem, substance abuse, eating disorder or has been physically/sexually abused, and treatment they have received.

4. List major illness and/or current physical health problems.

5. List medication currently taking and reason for medication.

6. List your physicians (local & hometown...address if not local)

CHECK ✓ THOSE THAT ARE *CURRENT* PROBLEMS. UNDERLINE ANY THAT HAVE BEEN *PAST* PROBLEMS.

- | | | |
|--|---|---|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Change in Appetite | <input type="checkbox"/> Shakiness |
| <input type="checkbox"/> Poor Social Relationships | <input type="checkbox"/> Loneliness | <input type="checkbox"/> Spiritual Concerns |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Internet Abuse | <input type="checkbox"/> Procrastination |
| <input type="checkbox"/> Career/Major Choice | <input type="checkbox"/> Chest Tightness | <input type="checkbox"/> Physical Health Problems |
| <input type="checkbox"/> Physical Abuse | <input type="checkbox"/> Dating Problems | <input type="checkbox"/> Lack of Ambition/Goals |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Excessive Perspiration | <input type="checkbox"/> Homicidal Thoughts |
| <input type="checkbox"/> Unhappiness | <input type="checkbox"/> Excessive Sleep | <input type="checkbox"/> Tiredness |
| <input type="checkbox"/> Death & Grief | <input type="checkbox"/> Unable to Concentrate | <input type="checkbox"/> Pornography |
| <input type="checkbox"/> Academic Problems | <input type="checkbox"/> Inferiority Feelings | <input type="checkbox"/> Guilty Feelings |
| <input type="checkbox"/> Sexual Problems | <input type="checkbox"/> Self Injury Behavior | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Nightmares | <input type="checkbox"/> Body Image Concerns | <input type="checkbox"/> Anger |
| <input type="checkbox"/> Marital Problems | <input type="checkbox"/> Stress | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Sexual Abuse | <input type="checkbox"/> Shyness | <input type="checkbox"/> Fears |
| <input type="checkbox"/> Drug Use | <input type="checkbox"/> Suicidal Thoughts | <input type="checkbox"/> Rapid/Skipping Heartbeat |
| <input type="checkbox"/> Adjusting to College Life | <input type="checkbox"/> Family Conflicts | <input type="checkbox"/> Poor Self Discipline |
| <input type="checkbox"/> Alcohol Use | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Roommate Conflict |
| <input type="checkbox"/> Gender Identity Problems | <input type="checkbox"/> Strange Thoughts | <input type="checkbox"/> Authority Conflict |

Is there any additional information you think your counselor needs to know?
