ASU COUNSELING CENTER CONSENT FORM

Billy C. Black Building Room 170
Days/Hours: Monday-Friday, 8 a.m.-5 p.m. (Appointments preferred)
(229) 500-2013 Main number (229) 500-4933 Fax
(229) 430-4711 ASU Police Department (Emergencies)

Welcome:
We want your experiences here to be positive. The following information provides background about the counseling center and your rights as a client. Ask your counselor if you have any questions.

Services:
The Albany State University Counseling Center offers a variety of individual, couples and group counseling services provided by licensed professionals and graduate interns as part of their mental health training programs. For training purposes, your session may be audio or video recorded. All care is overseen and supervised by the counseling director.

Counseling and psychotherapy can have both risks and benefits. Therapy sessions may include discussions of your personal challenges and difficulties which can elicit uncomfortable feelings (i.e., sadness, guilt, anger, and frustration). Therapy can often lead to better interpersonal relationships, improved academic performance, solutions to specific problems and reductions in your feeling of distress. However, there is no assurance of these benefits.

Confidentiality:
Records or information about a student's situation or condition will not be disclosed without a valid signed consent form from the student. However, staff have a legal responsibility to disclose client information without prior consent when a client is likely to harm him/herself, harm others unless protective measures are taken when there is reasonable suspicion of abuse of children, dependent adults or the elderly, when the client lacks the capacity to care for him/herself, and when there is a valid court order for the disclosure of client records. Fortunately, these situations are infrequent. If you elect to communicate with us via email, please be aware that email is not completely confidential.

Rights and Responsibilities:
You have the right to a copy of your file at any time. You have the right to request that we correct any errors in your file. You have the right to request that we make copies of your file available to any other health care provider at your written request. We keep very brief records and maintain your records in a secure location that cannot be accessed by anyone else.

You are responsible for coming to your session on time and at the time we have scheduled. Sessions last for forty-five minutes. If you are late, we will end on time so that we do not run into the next person's time. Please call to cancel or reschedule if you are unable to make it to your appointment.

You have the right to ask questions about therapy. We are always willing to discuss how and why we've decided to do what we're doing, and to look at alternatives that might work better. You can request that we refer you to someone else if you decide that we are not the right therapists for you. You are free to leave therapy at any time.

Normally, you will decide when therapy will end, with three exceptions: 1) if you are required to attend a certain number of sessions, 2) if we are unable to help you, 3) if we terminate you.

Consent:
I have read this statement and accept these terms.

Client signature_____Date_____

Witness signature_____Date_____

INTAKE FORM

Demographic Information:

Today's date_____

Name_____Ram ID_____DOB_____
Local Address_____
Permanent Address_____
Phone_____Email_____

Preferred method of contact_____
Emergency Contact (name, number & relationship)_____
_____
Ethnicity_____Marital Status_____
Classification_____Referred by_____
Religious preference_____

Current Concerns:
What brought you to the counseling center today?_____
_____
_____

What would you like to work on during your counseling sessions?_____
_____
_____

How long has this been a significant problem for you?_____
_____
_____

Have you ever been to counseling? If so, why?_____
_____
_____

Please list all medications you are currently taking._____
_____
_____

Do you use drugs or alcohol? If so, what and why?_____
_____
_____

Behavior-Circle any of the following that apply to you:

Overeating or Under eating	Suicide plans or attempts	Smoke	Crying	Difficulty concentrating
Insomnia	Vomiting	Drink too much	Aggressive behavior	Social anxiety
Withdrawal	Lack of motivation	Sleep too much	Compulsions	Nervousness
Work too hard	Procrastination	Cutting	Odd behavior	

Phobic avoidance	Outbursts of temper	Take too many risks	Impulsive reactions

Feelings-Circle any of the following that apply to you:

Angry	Guilty	Confident	Annoyed	Happy	Bored	Hopeless
Conflicted	Restless	Depressed	Valuable	Lonely	Anxious	Optimistic
Content	Fearful	Thankful	Excited	Isolated	Helpless	Paranoid
Energetic	Relaxed	Peaceful	Jealous	Sad		

Physical-Circle any of the following that apply to you:

Headaches	Chest pains	Unable to relax	Muscle spasms	Stomach problems
Twitches	Hear things	Dizziness	Rapid heart beat	Tension
Sexual Numbness	Back pain disturbances		Blackouts	Hearing problems
Bowel	Skin problems	Fainting disturbances	Watery eyes	
Visual	Fatigue	Tingling disturbances	Don't like being touched	

Suicidal thoughts or attempts, please explain_____
_____
_____

Any other concerns you would like your counselor to be aware of?_____
_____
_____