Wellness Center

406-447-5441
www.carroll.edu/wellness-center

CLIENT INFORMATION FORM

Carroll College

The Carroll Wellness Center is located on the ground floor of Guadalupe Hall next to the recreation room. Wellness Center hours are Monday through Friday, 9 a.m. to noon and 1 p.m. to 4 p.m.

For an initial counseling visit, please complete this form in advance of your visit and bring it with you to your appointment.

Today's date_____ Carroll ID #_____ Pronoun of choice _____

Name_____
First Middle/Initial Last Preferred

Date of birth_____ Age _____ Your phone # _____

Mailing address_____
Number and Street/Unit No. City State ZIP

May we email you? ☐ Yes ☐ No Email address_____

Would you like to receive appointment reminders by text? ☐ Yes ☐ No

• Emergency Contact Information

Name_____ Relation _____ Phone # _____

Mailing address_____
Number and Street/Unit No. City State ZIP

• Relationship Status

☐ Single
☐ Married—How long? _____
☐ Divorced—When? _____
☐ Separated—When? _____
☐ Serious dating/ committed relationship
☐ Widowed

• Carroll Status

☐ Freshman
☐ Sophomore
☐ Junior
☐ Senior
☐ Faculty/staff
☐ Other_____

Major_____ GPA_____

Are you a military veteran? ☐ Yes ☐ No If yes, do you receive support from Veterans Services? ☐ Yes ☐ No

Are you a transfer student? ☐ Yes ☐ No If yes, list where/when. _____

WHAT KIND OF HOUSING DO YOU CURRENTLY HAVE?

☐ On campus ☐ Off-campus apartment or house

If on campus, which hall? ☐ Guad ☐ St. Charles ☐ Borromeo ☐ Trinity ☐ Apartments

• Who referred you to our office?

☐ Self
☐ Friend
☐ Parent or spouse
☐ Faculty/staff (name) _____
☐ Health Services
☐ Community Living staff
☐ Coach/athletic trainer
☐ Other _____

• Family Relationships

Mother _____ _____ Living? ☐ *Yes* ☐ *No*
Name *Age*

Father _____ _____ Living? ☐ *Yes* ☐ *No*
Name *Age*

Sibling _____ _____ Living? ☐ *Yes* ☐ *No*
Name *Age*

Sibling _____ _____ Living? ☐ *Yes* ☐ *No*
Name *Age*

Sibling _____ _____ Living? ☐ *Yes* ☐ *No*
Name *Age*

Sibling _____ _____ Living? ☐ *Yes* ☐ *No*
Name *Age*

Step parent _____ _____ Living? ☐ *Yes* ☐ *No*
Name *Age*

Step parent _____ _____ Living? ☐ *Yes* ☐ *No*
Name *Age*

Other _____ _____ Living? ☐ *Yes* ☐ *No*
Name *Age*

• Parental Information

☐ Parents legally married
☐ Parents separated
☐ Parents divorced

☐ Mother remarried
Number of times _____
☐ Father remarried
Number of times _____

☐ Special circumstances (e.g., raised by person other than parents, information about spouse/children not living with you, etc.)
_____

• Development

Are there special, unusual, or traumatic circumstances that affected your development? ☐ Yes ☐ No

If yes, please describe. _____

Has there been history of child abuse? ☐ Yes ☐ No

If yes, type(s)? ☐ *Sexual* ☐ *Physical* ☐ *Verbal*

If yes, the abuse was as a ☐ *Victim* ☐ *Perpetrator*

Other childhood issues? ☐ Neglect ☐ Inadequate nutrition ☐ Other (please specify) _____

Comments about childhood development _____

• Social Relationships

Check how you generally get along with other people. (Check all that apply.)

☐ Affectionate ☐ Fight/argue often ☐ Leader ☐ Submissive
☐ Aggressive ☐ Follower ☐ Outgoing ☐ Other (specify)
☐ Avoidant ☐ Friendly ☐ Shy/withdrawn _____

Sexual orientation _____ Comments _____

• Cultural/Ethnic

To which cultural or ethnic group, if any, do you belong? _____

Are you experiencing any problems due to cultural or ethnic issues? ☐ Yes ☐ No

If yes, please describe. _____

Other cultural/ethnic information _____

• Spiritual/Religious

How important are spiritual matters to you? ☐ Not ☐ A little ☐ Moderately ☐ Very

Are you affiliated with a spiritual or religious group? ☐ Yes ☐ No

If yes, please describe. _____

Were you raised within a spiritual or religious group? ☐ Yes ☐ No

If yes, please describe. _____

Would you like your spiritual/religious beliefs incorporated into the counseling? ☐ Yes ☐ No

If yes, please describe. _____

• Legal

CURRENT STATUS

Are you involved in any active cases (traffic, civil, criminal)? ☐ Yes ☐ No

If yes, please describe and indicate the court and hearing/trial dates and charges. _____

_____

Are you presently on probation or parole? ☐ Yes ☐ No

If yes, please describe. _____

PAST HISTORY

Traffic violations? ☐ Yes ☐ No Criminal involvement? ☐ Yes ☐ No

DWI, DUI, etc.? ☐ Yes ☐ No Civil involvement? ☐ Yes ☐ No

If you responded yes to any of the above, please fill in the following information.

Charges _____

Date _____ Where (city) _____ Results _____

Charges _____

Date _____ Where (city) _____ Results _____

• Current Employment

Employer	Dates	Title	How often you miss work

• Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, traveling).

	Activity	How often now?	How often in the past?
	Activity	How often now?	How often in the past?
	Activity	How often now?	How often in the past?

• Physical Health

Please check all that apply.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Abdominal pain
- ☐ Abortion
- ☐ Anemia
- ☐ Bed wetting
- ☐ Cancer
- ☐ Chest pain
- ☐ Chronic pain
- ☐ Dental problems
- ☐ Diabetes
- ☐ Dizziness
- ☐ Drug abuse
- ☐ Epilepsy
- ☐ Eating problems
- ☐ Fainting
- ☐ Fatigue
- ☐ Headaches
- ☐ Hearing problems
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ Mononucleosis
- ☐ Menstrual pain
- ☐ Miscarriages
- ☐ Neurological disorders
- ☐ Nausea
- ☐ Nosebleeds
- ☐ Sexually transmitted diseases
- ☐ Sleeping disorders
- ☐ Sexual problems
- ☐ Thyroid problems
- ☐ Vision problems
- ☐ Vomiting
- ☐ Other (describe) _____

Current health concerns _____

Recent health or physical changes _____

NUTRITION

Breakfast _____ # per week	Lunch _____ # per week	Dinner _____ # per week	Snacks _____ # per week
Typical foods eaten	Typical foods eaten	Typical foods eaten	Typical foods eaten
Amount (low, medium, high)	Amount (low, medium, high)	Amount (low, medium, high)	Amount (low, medium, high)

Comments _____

MEDICATIONS

Current prescribed

Name of medication	Dose	Dates	Purpose	Side effects
Name of medication	Dose	Dates	Purpose	Side effects
Name of medication	Dose	Dates	Purpose	Side effects

Current over-the-counter

Name of medication	Dose	Dates	Purpose	Side effects
Name of medication	Dose	Dates	Purpose	Side effects
Name of medication	Dose	Dates	Purpose	Side effects

Are you allergic to any medications or drugs? ☐ Yes ☐ No *If yes, please describe.* _____

PHYSICAL AND EMOTIONAL CHANGES

Please check if there have been any recent changes in the following.

- ☐ Sleep patterns
- ☐ Eating patterns
- ☐ Behavior
- ☐ Energy level
- ☐ Physical activity level
- ☐ General disposition
- ☐ Weight
- ☐ Nervousness/ tension

Describe changes in areas you checked above. _____

• Chemical Use History

	Method of use and amount	Frequency of use	Age at first use	Age at last use	Used in last 48 hrs?	Used in last 30 days?
Alcohol						
Barbiturates						
Valium/Librium						
Cocaine/crack						
Heroin/opiates						
Marijuana						
PCP/LSD/Mescaline						
Inhalants						
Caffeine						
Nicotine						
Over the counter						
Prescription drugs						
Other drugs						

SUBSTANCE OF PREFERENCE

1. _____ 2. _____ 3. _____

SUBSTANCE ABUSE QUESTIONS

Describe when and where you typically use substances. _____

Describe any changes in your use patterns. _____

Describe how your use has affected your family or friends (include their perceptions of your use). _____

_____

Reason(s) for use:

☐ Addicted ☐ Escape ☐ Socialization ☐ Other (specify) _____

☐ Build confidence ☐ Self-medication ☐ Taste

How do you believe your substance use affects your life? _____

Who or what has helped you in stopping or limiting your use? _____

Does/has someone in your family present/past have/had a problem with drugs or alcohol? ☐ Yes ☐ No

If yes, please describe. _____

Have you had withdrawal symptoms when trying to stop using drugs or alcohol? ☐ Yes ☐ No

If yes, please describe. _____

Have you had adverse reactions or overdose to drugs or alcohol? ☐ Yes ☐ No

If yes, please describe. _____

Does your body temperature change when you drink? ☐ Yes ☐ No

If yes, please describe. _____

Have drugs or alcohol created a problem for your job or school? ☐ Yes ☐ No

If yes, please describe. _____

• Counseling/Prior Treatment History

YOUR INFORMATION (PAST AND PRESENT)

Counseling/psychiatric ☐ Yes ☐ No If yes, when? _____ where? _____

Your reaction to the overall experience_____

Suicidal thoughts ☐ Yes ☐ No If yes, when?_____ where? _____

Your reaction to the overall experience_____

Suicidal attempts ☐ Yes ☐ No If yes, when?_____where?_____ how attempted? _____

Your reaction to the overall experience_____

Drug/alcohol treatment ☐ Yes ☐ No If yes, when?_____ where? _____

Your reaction to the overall experience_____

Psychiatric hospitalizations ☐ Yes ☐ No If yes, when? _____ where? _____

Your reaction to the overall experience_____

*Involvement with self-help group*s (e.g., AA, Al-Anon, NA, Overeaters Anonymous) ☐ Yes ☐ No

If yes, when? _____ where? _____

Your reaction to the overall experience_____

INFORMATION ABOUT FAMILY/SIGNIFICANT OTHERS (PAST AND PRESENT)

Counseling/psychiatric ☐ Yes ☐ No If yes, who? _____ when?_____ where? _____

Suicidal thoughts/attempts ☐ Yes ☐ No If yes, who? _____ when?_____ where? _____

Drug/alcohol treatment ☐ Yes ☐ No If yes, who?_____ when?_____ where? _____

Psychiatric hospitalizations ☐ Yes ☐ No If yes, who? _____ when?_____ where? _____

Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous) ☐ Yes ☐ No

If yes, who? _____ when?_____ where? _____

• Behaviors

Please check behaviors and symptoms that occur to you more often than you would like them to take place.

- ☐ Aggression
- ☐ Alcohol dependence
- ☐ Anger
- ☐ Antisocial behavior
- ☐ Anxiety
- ☐ Avoiding people
- ☐ Chest pain
- ☐ Cyber addiction
- ☐ Depression
- ☐ Disorientation
- ☐ Distractibility
- ☐ Dizziness
- ☐ Drug dependence
- ☐ Eating disorder
- ☐ Elevated mood
- ☐ Fatigue
- ☐ Gambling
- ☐ Hallucinations
- ☐ Heart palpitations
- ☐ High blood pressure
- ☐ Hopelessness
- ☐ Impulsivity
- ☐ Irritability
- ☐ Judgment errors
- ☐ Loneliness
- ☐ Memory impairment
- ☐ Mood shifts
- ☐ Panic attacks
- ☐ Phobias/fears
- ☐ Recurring thoughts
- ☐ Sexual addiction
- ☐ Sexual difficulties
- ☐ Sick often
- ☐ Sleeping problems
- ☐ Speech problems
- ☐ Suicidal thoughts
- ☐ Thoughts disorganized
- ☐ Trembling
- ☐ Withdrawing
- ☐ Worrying
- ☐ Other (specify) _____

Briefly discuss how the above symptoms impair your ability to function effectively. _____

_____

_____

Any additional information that would assist us in understanding your concerns or problems _____

_____

_____

_____

_____

What are your goals for therapy?_____

_____

_____

_____

_____

Do you feel suicidal at this time? ☐ Yes ☐ No

*If yes, please explain.*_____

_____

_____

(Continued on other side.)

• For Staff Use

Therapist's signature/credentials _____ Date _____

Referral for Denise: ☐ Required ☐ Not Required

Referral for Kerri: ☐ Required ☐ Not Required

Referral for outside therapist: ☐ Required ☐ Not Required

COUNSELING CENTER—INFORMED CONSENT

COUNSELING CENTER INFORMED CONSENT

Counseling Services adheres to strict confidentiality guidelines set by Montana State Code and by the American Counseling Association Code of Ethics. All conversations, both by telephone and in person, are confidential. Any and all records kept by Counseling Services relating to clients are kept confidential, except in the following cases:

a. When the client is determined to be a threat to the health and safety of him/herself or another, including abuse of a child, elder or disabled adult.

b. When documents are court ordered to be released to the property of the court.

c. When Carroll College Counseling Service's staff and/or Carroll College Health Services staff discuss case material for the purpose of consultation, supervision, or treatment planning.

d. When the client has given written consent to share specified information with identified person(s).

ADDITIONAL INFORMATION

a. Individual sessions are usually 50 minutes in length.

c. Our goal is to provide brief, solution-focused counseling to help with immediate mental health and emotional needs. Students with intensive and on-going therapy needs beyond our scope will be given assistance in locating and securing community-based counselors who can provide a higher level of care. This includes following discharge from the hospital for psychiatric care.

d. Hard copy client records are shredded after 7 years.

e. Client records are accessible only to Counseling Service's staff. Counseling Services records are not part of Health Services, Student Life or Academic records.

f. E-mail and faxes are not secure media; therefore, confidentiality of e-mail and facsimiles cannot be guaranteed. Timeliness of response to a facsimile or email message cannot be guaranteed.

CLIENT RIGHTS AND RESPONSIBLITIES

a. You have a right to confidentiality within the limitations described above.

b. You have the right to be involved in your goal setting/treatment planning process and to be informed of the professional members of your treatment team.

c. You have the right to be informed of any potential benefits or risks associated with your treatment. It is not uncommon for symptoms to worsen before they improve.

d. You have the right to refuse treatment.

e. You have the right to receive treatment from competent mental health care professionals who respect your individualized needs. (Please inform your counselor if you do not believe you are being understood and/or respected.)

f. You have the right to request another mental health care professional within the department or a referral to an outside professional.

g. For clients 18 years of age or older, access to records/treatment information is available only with a written release of information form, signed by the client.

h. Please call to cancel/reschedule: Call 406-447-5441, as soon as you know you will need to miss an appointment—24 hrs. notice is appreciated.

i. **If you are more than 15 minutes late for an appointment you may be asked to reschedule.**

EMERGENCY SERVICES

In the event of an emergency, call Community Living at 406-459-0540, Campus Security at 406-461-7611, or 911, or obtain safe transportation to St. Peter's Hospital Emergency Room located at 2475 E. Broadway Avenue, Helena, MT.

I have read and understand the above statements. I have had the opportunity to ask questions about the statements above and have been provided with a copy of this form.

Client signature _____ Date _____

Client printed name _____

Counselor signature _____ Date _____

Parent/guardian signature (if client is under 18) _____ Date _____