Mount Aloysius College
Psychological Services

Confidential

Privacy of Information – Limits of Confidentiality
Consent to Evaluation and Treatment

It is the policy of Mount Aloysius College not to release personally identifiable information concerning the use of our psychological services without the prior permission of the person who was counseled. We shall be glad to send a report or to talk with any person(s) you designate if a release form is signed by you. A copy of this form is available to you from your psychologist.

Legally and ethically, there are circumstances that limit confidentiality. Information discussed in the counseling setting is held confidential and will not be shared without written permission except under the following conditions:

1. The student threatens harm to self.
2. The student threatens harm to another person(s), including death, assault, or other physical harm.
3. The student's behavior becomes disruptive to the College community.
4. There is evidence to suggest that physical or sexual child abuse has occurred.
5. A valid medical emergency occurs.
6. A legitimate subpoena or court order is received.

State law mandates that psychologists may need to report these situations to the appropriate persons and/or agencies. Communication between the psychologist and student will otherwise be deemed confidential as stated under the laws of this state.

Having read and understood the above information, I, _____, am voluntarily presenting myself for evaluation and treatment by authorized agents and employees of Mount Aloysius College or their designees, as may in their professional judgment be deemed necessary or beneficial.

I acknowledge that no guarantees have been made to me as to the effect of any such treatment or service, and understand that I may, at any time, refuse such treatment. I understand that giving this consent does not waive my civil rights, and I reserve the right to decline any treatment that I believe is not in my best interest.

I understand that my records are confidential and will not be released to other individuals or agencies without my express written consent. However, I realize that certain information, as described above, may be released without my authorization.

My signature below constitutes my acknowledgement that I have read, understood, and agree to the foregoing, and that I hereby give authorization and consent. I have received a copy of this form.

_____ _____

Client Signature *Date*

_____ _____

Counselor Signature *Date*

_____ _____

Witness Signature *Date*

Mount Aloysius College

Student Health and Counseling Services

Patient's Rights and Responsibilities

Patient's Rights

- You have the right to be treated with dignity and respect.
- You have the right to fair treatment regardless of your race, religion, gender, ethnicity, age, or ability level.
- You have the right to easily access care in a timely fashion.
- You have the right to share in developing you plan of care.
- You have the right to have a clear explanation of your condition and treatment options.
- You have a right to information about clinical guidelines used in providing your care.
- You have the right to give input into your treatment.
- You have the right to know about advocacy and community groups and prevention services available in the local community.
- You have a right to know your rights and responsibilities in the treatment process.
- You have a right to receive services from qualified professionals.

Patient Signature_____

Patient's Responsibilities

- You have the responsibility to treat those giving you care with dignity and respect.
- You have the responsibility to give care providers the information they need to provide the best possible care.
- You have the responsibility to follow treatment recommendations.
- You have the responsibility to ask questions about your care. This is to help you understand the care you are receiving.
- You have the responsibility to keep your appointments. You should call your provider as soon as you know you need to cancel your appointment.
- You have the responsibility to let your provider of care know when treatment is not working.
- You have the responsibility to openly report concerns about the quality of care you receive.

Provider Signature_____

Client Intake Questionnaire

Date _____

Social Security # _____ Student ID # _____

Name _____

Phone(s): Home _____ Cell _____ E-Mail _____

May we contact you by?

Mail/Letter	☐ YES	☐ NO			
E-Mail	☐ YES	☐ NO			
Phone					
Home	☐ YES	☐ NO	Leave a message?	☐ YES	☐ NO
Cell	☐ YES	☐ NO	Leave a message?	☐ YES	☐ NO

Local Residence _____
Residence Hall/Street Address Room/Apt. # City State Zip

Mailing Address _____
Residence Hall/Street Address Room/Apt. # City State Zip

In an emergency, the Counseling Center has my permission to contact the following (parent, spouse, etc.)

Name _____
Last First Relationship

Phone _____ Address _____
Street Apt. # City State Zip

Insurance
Carrier Name _____ Policy Number _____ Address _____

Academic Status
- ☐ Freshman (0-29 hrs.)
- ☐ Sophomore (30-59 hrs.)
- ☐ Junior (60-89 hrs.)
- ☐ Senior (90+ hrs.)
- ☐ Graduate Student
- ☐ Dental Student
- ☐ Post Baccalaureate

- ☐ Single
- ☐ Committed Relationship
- ☐ Separated
- ☐ Divorced
- ☐ Widowed
- ☐ Other _____

Ethnic/Racial identification (Optional)
- ☐ Black/African American
- ☐ Native American/Alaskan Native
- ☐ Asian/Asian American/ Pacific Islander
- ☐ Latino(a)/Hispanic
- ☐ Caucasian/White American
- ☐ Biracial/Multiracial
- ☐ Other _____

Referral Source
- ☐ Self Referred
- ☐ Friend
- ☐ Relative

Physician _____
Name

Faculty/Staff _____
Name or Department

Disciplinary _____
Name

Are you (Optional)
- ☐ US Citizen
- ☐ Non-Citizen Resident
  Country of Origin _____
- ☐ International Student
  Country of Origin _____

Living Situation
- ☐ Alone
- ☐ Roommate(s)
- ☐ Partner/Spouse
- ☐ Parent(s)
- ☐ Children
- ☐ Other _____

Sexual Orientation (Optional)
- ☐ Straight/Heterosexual
- ☐ Gay/Homosexual
- ☐ Bi/Bisexual
- ☐ Not Sure
- ☐ Not Disclosed

Date of Birth _____
Gender ☐ Male ☐ Female

Cumulative GPA _____
Current Credit Hours _____
Hours Employed _____

Current Medications _____
_____

Employment Status
☐ Not Employed ☐ Employed
Type of Work _____

Expected Graduation _____
Major _____

Transfer: ☐ NO ☐ YES, from _____
Physical or Learning Disability (if applicable) _____

Is this a crisis? ☐ YES ☐ NO If YES, please explain

_____

_____

Have you used our services before? ☐ YES ☐ NO If YES, when, whom did you see, what was the major issue?

Have you had previous counseling or other mental health services? ☐ YES ☐ NO If YES, when, where, what was the major issue?

Have you ever seriously considered or attempted suicide? ☐ YES ☐ NO If YES, please explain the circumstances.

Do you have any significant medical conditions or significant medical history? ☐ YES ☐ NO If YES, please explain.

Do you have any significant legal history or current legal issues pending? ☐ YES ☐ NO If YES, please explain.

Are you currently taking any medications? ☐ YES ☐ NO If YES, what and for how long?

Please describe your use of alcohol, cigarettes, and recreational drugs.

Describe any events or situations in your childhood that may be affecting your current functioning or situation (e.g. abuse, tornado, death in the family, etc.).

How would you describe yourself?

What would you like to accomplish in counseling? What about your behavior and feelings would you like to change?

Please complete the following:

I am a person who _____

It's hard for me to admit _____

One of the things I can't forgive _____

The thing I fell most guilty about is _____

If I didn't have to worry about my image _____

Some of the ways people hurt me are _____

What I wanted from my father and didn't get was _____

What I wanted from my mother and didn't get was _____

The bad thing about growing up is _____

If I weren't afraid to be myself, I might _____

One of the ways I could help myself, but don't is _____

Self-Report Checklist

Please rate any issues below that are concerning you by choosing the appropriate number (0, 1, 2 3).

Schoolwork and grades	No Problem	Mild	Moderate	Severe
Procrastination, motivation, and time management	0	1	2	3
Academic anxieties (stage fright, speaking, tests)	0	1	2	3
Decision about major/career	0	1	2	3
Adjustment to the University	0	1	2	3
Learning Disabilities	0	1	2	3
Finances/money matters	0	1	2	3
Relationships with friends	0	1	2	3
Living situation/roommate	0	1	2	3
Loss/death of significant person	0	1	2	3
Divorce (own, family)	0	1	2	3
Relationship with romantic partner	0	1	2	3
Relationships with family & parents	0	1	2	3
Sexual orientation issues	0	1	2	3
Gender identity issues	0	1	2	3
Sexual decisions/issues	0	1	2	3
Pregnancy/abortion issues	0	1	2	3
Sexually transmitted diseases	0	1	2	3
Childhood sexual abuse/molestation	0	1	2	3
Childhood physical abuse/emotional abuse/neglect	0	1	2	3
Rape/sexual assault	0	1	2	3
Sexual harassment	0	1	2	3
Discrimination/oppression (e.g. racism, sexism, homophobia)	0	1	2	3
Legal matters	0	1	2	3
Religious/spiritual issues	0	1	2	3
Shyness, being assertive	0	1	2	3
Self-esteem, self confidence	0	1	2	3
Loneliness, homesickness	0	1	2	3
Depression	0	1	2	3
Anxiety, fears, worries	0	1	2	3
Irritable, angry, hostile feelings	0	1	2	3
Suicidal feelings/behavior	0	1	2	3
Dealing with physical disability	0	1	2	3
Chronic health problems	0	1	2	3
Physical stress (headaches, stomach pains, muscle tension)	0	1	2	3
Stress	0	1	2	3
ADHD	0	1	2	3
Sleeping problems	0	1	2	3
Eating problems	0	1	2	3
Alcohol and/or other drugs (self, family, partner, friend)	0	1	2	3
Other (Please specify):	0	1	2	3