FAIRLEIGH DICKINSON UNIVERSITY – COLLEGE AT FLORHAM
COUNSELING AND PSYCHOLOGICAL SERVICES (CAPS)

Dear FDU Student,

Welcome to CAPS! We are glad that you have made the first step and look forward to assisting you. You are about to have an intake interview with one of our counselors. The following information is intended to give you a sense of what to expect during your first session and CAPS procedures.

Your first meeting and subsequent sessions will last 45 minutes. During that time, you and your counselor will discuss your concerns and what type of services will best fit your needs. This may mean remaining at CAPS for brief individual therapy or being referred to an outside provider. In instances where there is a concern that you are engaging in behavior that places you or someone else at risk, our policy is to require that you receive further assessment to determine your current treatment needs.

We invite questions you may have about the counseling process or our polices. We encourage you to talk with your counselor if at any time you feel uncomfortable with any aspect of your involvement.

Sincerely,
The CAPS Team

FDU COUNSELING SERVICES CLIENT CONSENT FORM

COUNSELING is a confidential process designed to help you address your concerns, come to a greater understanding of yourself, and learn effective personal and interpersonal coping strategies. It involves a relationship between you and a trained therapist who has the desire and willingness to help you accomplish your individual goals. Counseling involves sharing sensitive, personal, and private information that may at times be distressing. During the course of counseling, there may be periods of increased anxiety or confusion. The outcome of counseling is often positive; however, the level of satisfaction for any individual is not predictable. Your therapist is available to support you throughout the counseling process.

CONFIDENTIALITY: All interactions with Counseling Services, including scheduling of or attendance at appointments, content of your sessions, progress in counseling, and your records are confidential. No record of counseling is contained in any academic, educational, or job placement file. You may request in writing that the counseling staff release specific information about your counseling to persons you designate.

EXCEPTIONS TO CONFIDENTIALITY:

- The counseling staff works as a team. Your therapist may consult with other counseling staff to provide the best possible care. These consultations are for professional and training purposes.

- If there is evidence of clear and imminent danger of harm to self and/or others, a therapist is legally required to report this information to the authorities responsible for ensuring safety. This may include other campus offices, parents, the local hospital, or, in rare instance, Public Safety or the local police department. Reasonable efforts will be made to inform you if such information is to be released.

- New Jersey state law requires that staff of Counseling Services who learn of, or strongly suspect, physical or sexual abuse or neglect of any person under 18 years of age must report this information to The Department of Children & Families (DCF).

- A court order, issued by a judge, may require Counseling Services staff to release information contained in records and/or require a therapist to testify in a court hearing.

Please be aware that email is not confidential. CAPS may utilize email only for administrative matters such as referrals. As a result, we ask that you do no relay any important or urgent personal concerns via email.

There is no fee for counseling services. Please be prompt for your session. Twenty-four hour notice of cancellation allows us to use the time for others. If you are referred off campus to health, mental health, or substance abuse professionals you are responsible for their charges.

Your signature below indicates that you have read the information in this document and agree to abide by its terms while you are being seen at FDU CAPS.

_____

Signature of Client *Date*

_____

Signature of Therapist *Date*

Rev. 1/16

FAIRLEIGH DICKINSON UNIVERSITY COUNSELING & PSYCHOLOGICAL SERVICES (CAPS)

Student Intake Assessment Form

Date: _____/_____/_____ Student ID: _____ Date of Birth: _____/_____/_____ Age: _____

First Name: _____ Middle:_____ Last: _____
Preferred Name:_____

STUDENT INFORMATION

Gender: □ Female □ Male □ Transgender □ Other (Identify) _____

ETHINICITY: Check all that apply
□ African American □ Latino/Hispanic □Asian American □ Multiracial
□Caucasian □ Native American □Other_____

SEXUAL ORIENTATION:
□Heterosexual □Bisexual □ Gay □Lesbian □Asexual □ Questioning □Prefer not to answer

RELATIONSHIP STATUS:
□Single □ Casual dating □Partnered □Married □Divorced □Separated □Widowed □Other

RESIDENCE: (check and specify in detail below):
□ Residence Hall Local Residence Address: _____
□ Off campus-residence
□ Parent's/Relative's Home Permanent Address (if different):
_____

CONTACT INFORMATION: (check all that apply)
Cell Phone # _____ □ Ok to call? □ Ok to leave message?

Home or Other Phone # _____ □ Ok to call? □Ok to leave message?
Preferred email address: (please be aware that email may not be confidential)_____
□ Ok to email ?

EMERGENCY CONTACT: (Permission to speak with listed person in an emergency situation)
Name:_____ Relationship: _____ Phone:_____

ACADEMIC STATUS:
□ FR □ SO □ JR □ SR □ GRAD STUDENT
Major:_____ Minor: _____
Credits this semester: GPA:

ARE YOU CURRENTLY EMPLOYED?
□ Yes □ No □On-Campus □Off-Campus # of hours per week

Please list any clubs, organizations, college sports, hobbies, extra-curricular activities you are involved with:

_____
_____
_____
_____
_____

OTHER INFORMATION:

Veteran: □No □ Yes (Branch) _____ Dates of Service:_____

International Student □ No □Yes – Country _____

STAFF NOTES:

FAIRLEIGH DICKINSON UNIVERSITY COUNSELING & PSYCHOLOGICAL SERVICES (CAPS)

Student Intake Assessment Form

Transfer Student: □ No □ Yes Please list school and GPA _____

Student with disabilities: □ No □Yes (Diagnosis) _____
Are you officially registered with FDU Office with Student Disabilities program? □ Yes □No

First in your family to attend college (excluding siblings)? □ Yes □ No

WHO WERE YOU REFERRED BY?
□ Self □Professor/TA □Friend □ Parent □Dean □ Academic Advisor □ Other (specify) : _____

PRESENTING CONCERNS:

Briefly describe what brings you here today:
_____
_____
_____
_____
_____

Approximately how long has this concern been bothering you?
□ Day □ Week □ Month □ Several Months □ Year □ Several Years □ Most of my life

MENTAL HEALTH HISTORY: ***

Have you received counseling in the past? □Yes □No
If yes, please indicate:
Where:_____
Counselor's Name:_____
Duration:_____

Are you CURRENTLY taking any prescribed psychiatric medications, antidepressants, or others?
□ Yes (specify below) □ No
Please indicate the names of medications, dosages and the psychiatrist/physician who prescribed the medication(s).
_____
_____
_____
_____

Have you been prescribed medication in the PAST? □Yes □ No If yes, please list medication and dosage information:
_____

Have you ever been hospitalized for psychiatric reasons? □ Yes, specify below □ No Dates hospitalized: _____
If YES, please specify reasons (check all that apply): □ Psychological problems □ Suicide ideation/attempt □ Dangerousness to others
□ Drug/alcohol □ Other, please specify :

Have you ever had thoughts of harming yourself (purposely injuring self <u>without</u> suicide intent : cutting, hitting, burning, scratching, hair pulling, etc). □ No □ Yes If Yes, when did this occur? □ In the past but stopped □ In the past and currently going on □ Recently started

In the last few days, have you had **suicidal thoughts?** □ Yes (specify below) □ No
If YES, please answer following: DURATION: □ Seconds □ Minutes □ Hours □ Constant INTENSITY: □Brief and fleeting
□Focused deliberation □Intense rumination
Do you have a plan?
Have you ever made a **suicide attempt**? □ Yes (specify) □No

STAFF NOTES:

If YES, please describe when and the nature of the attempt:
_____
_____

Did you receive help? If so, please describe when and the nature of the help you received:_____
_____

Have you ever seriously **considered attempting suicide** in the past? □ Yes (specify) □No

Are you currently seriously considering **harming another person or have you seriously considered in the past?** □ Yes (specify) □ No
Describe when, how etc. :

Have you ever in the past **intentionally physically harmed someone**? □ Yes (specify) ◘ No

SUBSTANCE USE

How often do you drink alcohol: (Circle one the best describes your drinking habits)
Never Daily or almost daily Several times a week Once a week Monthy Other (specify) _____

In a typical month, how often do you have **4 OR MORE DRINKS** in a 24-hour period? (Circle one)
Never Rarely Monthly Weekly Daily or almost daily

Do you consider your alcohol consumption a problem? □ Yes □No □ N/A

Have you used any drug in the past 30 days that wasn't prescribed by a physician? (e.g. marijuana, meth, cocaine, diet pills, heroin, Ritalin, Adderall, etc). □ Yes (specify below) □ No
Please tell what drugs and when last used:

How often do you engage in recreational drug use? (Circle one) Do you consider your drug use a problem? □ Yes □ No

Never Rarely Monthly Weekly Daily or almost daily

HEALTH AND SOCIAL ISSUES

How is your physical health at present? □Poor □Unsatisfactory □ Satisfactory □Good □Excellent

Have you ever had any serious accidents, injuries or illnesses? □ No □ Yes
If yes, describe:

Are you presently taking any medications (prescribes medications, over the counter, alternative remedies etc.)
If yes, list:

List any PERSISTENT PHYSICAL SYMPTOMS or health concerns: (e.g. headaches, chronic pain, hypertension, diabetes etc.)

How are your sleeping patterns? □ No problems □Sleep too much □Sleep too little □ Poor quality of sleep □ Disturbing dreams

How many times a week do you exercise? □ None □ Once a week □2-4 □ 5 or more For about how long each time?

STAFF NOTES:

FAIRLEIGH DICKINSON UNIVERSITY COUNSELING & PSYCHOLOGICAL SERVICES (CAPS)

Student Intake Assessment Form

During the past month, are you having any difficulty with your appetite or eating habits? Check all that apply:
□ No difficulty □ Eating Less □ Eating More □Bingeing □ Restricting □ Weight loss or gain? If so how much, _____
□ Counting calories □ Dieting □Diet pills □Laxatives □ Diuretics □ Other _____

Do you have any problems or worries about sexual functioning?
□ No concerns □ Lack of desire □ Performance problem □ Sexual impulsiveness □ Worried about STD □ Other, specify _____

Whom do you consider your social support(s)? (family, friends, significant others, no one etc.)

Are you in a significant intimate relationship currently? If yes, for how long?

Have you ever experienced the following in the past or currently? : (check all that apply and elaborate on below)
□Had unwanted sexual contact(s) □Experienced harassing, controlling, and/or abusive behavior from another person □ Frequent gambling
□Sexual identity or gender concerns □ Test anxiety □ Physical abuse □Sexual Abuse □ Emotional abuse
□Family member diagnosed with a chronic or current illness □ Abortion
□ Death of a friend, family member or pet □ Mania □ Other _____
Please explain in further detail:

FAMILY & CULTURAL BACKGROUND

Please list immediate family members including ages & occupation: (Sally, mother, 50, accountant):

Religious preference: _____ To what extent does religion play an important role in your life:
□ Very important □ Important □ Neutral □ Unimportant □ Very unimportant

Is there any other information that you feel is important to share with us? Please describe:

STAFF NOTES: