SWOSU™

Southwestern Oklahoma State University

Student ID_____ **Date**_____

PERSONAL INFORMATION

First Name _____ MI _____ Last Name _____

Age _____ Date of Birth _____ Referred by _____

Sexual Orientation:_____ Ethnicity _____

Insurance Provider: _____

CONTACT INFORMATION

Local Address		
City	State	Zip
Phone Number	Cell Phone Number	
SWOSU Email Address		
Hometown/Country		
Last Visit to PCP- (Primary Care Physician)		
Are you registered with the office for disability services, as having a documented and diagnosed disability? If so, please include.		

EMERGENCY CONTACT INFORMATION

First Name	MI	Last Name
Phone Number		
City	State	Zip
Relationship to student		

ACADEMIC/CAREER INFORMATION

Freshman	Sophomore	Junior	Senior	Graduate

Major/Minor	GPA	Advisor
Future Plans		
Current Job or Career		
Organized SWOSU groups/athletics that you participate in		

What brings you to our office?

_____

_____

When did you first notice the problem?

_____

How likely do you think it is that the problem can be resolved? (circle one)

1	**2**	**3**	**4**	**5**
Very unlikely	Somewhat unlikely	Unsure	Somewhat likely	Very likely

How will you know when the problem is resolved? What will be different?

_____

_____

Briefly describe your goals for treatment:_____

_____

Are you willing to complete homework assignments from your counselor between sessions?_____

BEHAVIOR/HEALTH

Do you exercise? If so, how often?

_____

Have there been any recent changes in your eating habits?

_____

Have there been any recent changes in your sleeping habits?

_____

What do you do for fun?

_____

Do you have habits that may be viewed as unhealthy? (Ex. gambling, pornography, binge drinking)

_____

Do you have any other health concerns at this time that may need medical attention?

_____

Are you experiencing any chronic pain currently?

_____

RELATIONSHIPS

Who are the people in your life that you can rely on during difficult times?

_____

Are you in a relationship? If so, are you currently happy with it?

_____

How are your family relationships?

_____

Do you have children? If so, how many?

_____

Are you currently experiencing any abuse in your relationships? (Physical, emotional, sexual)

_____

SPIRITUALITY

What are your spiritual beliefs?

_____

SUBSTANCE USE

How much caffeine do you consume per day? _____

Please list any substances you use regularly (e.g., tobacco products, alcohol, marijuana, other drugs):

_____

Have you ever felt concerned about your drug or alcohol intake?

_____

Do you have any family members who have struggled with addiction?

_____

AFFECT/MOOD

Circle any of the following that describe how you feel on a regular basis.

Excited	Hyper	Restless	Optimistic	Cheerful	Content	Hopeful	Calm
Depressed	Alone	Hurt	Hopeless	Lost	Distressed	Unhappy	Moody
Furious	Enraged	Betrayed	Upset	Mad	Annoyed	Irritable	Defensive
Panicky	Frantic	Scared	Apprehensive	Threatened	Insecure	Intimidated	Nervous
Worthless	Sorrowful	Guilty	Ashamed	Unworthy	Secretive	Embarrassed	Regretful

Do you engage in self-harming behaviors (cutting, scratching, hitting, burning, purging)?

_____

Do you have thoughts of death, suicide, or plans to attempt suicide? If yes, please describe.

_____

_____

_____

Have you attempted suicide in the past? How? When?

_____

_____

Has anyone in your family ever attempted suicide or died by suicide? Yes_____ No_____

Have you ever received treatment for mental health (inpatient or outpatient)? If so, please list dates and reason(s):

_____

_____

Current Medications:

_____

_____

Current or Previous Mental Health Diagnosis:

_____

_____

ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING? Check all that apply

- ☐ Lower Academic Performance
- ☐ Poor Class Attendance
- ☐ Social Avoidance/Withdrawal
- ☐ Eating/Weight/Body Image
- ☐ Anxiety
- ☐ Social Anxiety
- ☐ Perfectionism
- ☐ Phobias/Extreme Fears
- ☐ Obsessive Thinking
- ☐ Compulsive Behaviors (checking, counting, cleaning)
- ☐ Agitation/Restlessness
- ☐ Athletics/Sports Performance
- ☐ Depression
- ☐ Decreased Interest/Pleasure
- ☐ Fatigue/Low Energy
- ☐ PTSD/Flashbacks/Nightmares
- ☐ Grief/Loss
- ☐ Auditory/Visual Hallucinations
- ☐ Marijuana Abuse
- ☐ Prescription Medication Abuse
- ☐ Stimulant Abuse
- ☐ Opiate Abuse
- ☐ Sedative/Hypnotic/Hallucinogen Abuse
- ☐ Other Drug Abuse
- ☐ Other Addictive Behaviors (gambling, porn, internet)
- ☐ Suicidal Thoughts
- ☐ Homicidal Thoughts/Violence
- ☐ University Disciplinary/Conduct Issues
- ☐ Legal/Arrest/Police Involvement
- ☐ Referral by Attorney/Court
- ☐ Financial Stress Now

Please select any traumatic events(s) you have experienced:

- ☐ Childhood abuse (physical, emotional, sexual)
- ☐ Childhood neglect
- ☐ Domestic Violence in the home
- ☐ Substance abuse by parent or caregiver
- ☐ Physical attack
- ☐ Sexual violence
- ☐ Military combat or war zone experiences
- ☐ Kidnapped or taken hostage
- ☐ Serious accident, fire, or explosion
- ☐ Near drowning
- ☐ Diagnosed with life threatening illness
- ☐ Natural disaster
- ☐ Imprisonment or torture
- ☐ Imprisonment of parent or caregiver
- ☐ Parents separated or divorced

Thank you for coming to see us today. Your time is very important to us.

Please return this packet to the reception desk. Someone will be with you shortly.

THE BURNS ANXIETY INVENTORY

Name: _____ Date: _____

	INSTRUCTIONS: The following is a list of symptoms that people sometimes have. Put a checkmark in the space to the right that best describes how much that symptom or problem has bothered you during this past week.	0 - NOT AT ALL	1 - SOMEWHAT	2 - MODERATELY	3 - A LOT
ANXIOUS FEELINGS					
1	Anxiety, nervousness, worry, or fear	☐	☐	☐	☐
2	Feeling that the things around you are strange, unreal, or foggy	☐	☐	☐	☐
3	Feeling detached from all or part of your body	☐	☐	☐	☐
4	Sudden unexpected panic spells	☐	☐	☐	☐
5	Apprehension or a sense of impending doom	☐	☐	☐	☐
6	Feeling tense, stressed, "uptight", or on edge	☐	☐	☐	☐
ANXIOUS THOUGHTS					
7	Difficulty concentrating	☐	☐	☐	☐
8	Racing thoughts or your mind jumps from one thing to the next	☐	☐	☐	☐
9	Frightening fantasies or daydreams	☐	☐	☐	☐
10	Feeling that you're on the verge of losing control	☐	☐	☐	☐
11	Fears of cracking up or going crazy	☐	☐	☐	☐
12	Fears of fainting or passing out	☐	☐	☐	☐
13	Fears of physical illness or heart attacks or dying	☐	☐	☐	☐
14	Concerns about looking foolish or inadequate in front of others	☐	☐	☐	☐
15	Fears of being alone, isolated, or abandoned	☐	☐	☐	☐
16	Fears of criticism or disapproval	☐	☐	☐	☐
17	Fears that something terrible is about to happen	☐	☐	☐	☐
PHYSICAL SYMPTOMS					
18	Skipping or racing or pounding of the heart (palpitations)	☐	☐	☐	☐
19	Pain, pressure, or tightness in the chest	☐	☐	☐	☐
20	Tingling or numbness in the toes or fingers	☐	☐	☐	☐
21	Butterflies or discomfort in the stomach	☐	☐	☐	☐
22	Constipation or diarrhea	☐	☐	☐	☐
23	Restlessness or jumpiness	☐	☐	☐	☐
24	Tight, tense muscles	☐	☐	☐	☐
25	Sweating not brought on by heat	☐	☐	☐	☐
26	A lump in the throat	☐	☐	☐	☐
27	Trembling or shaking	☐	☐	☐	☐
28	Rubbery or "jelly" legs	☐	☐	☐	☐
29	Feeling dizzy, lightheaded, or off balance	☐	☐	☐	☐
30	Choking or smothering sensations or difficulty breathing	☐	☐	☐	☐
31	Headaches or pains in the neck or back	☐	☐	☐	☐
32	Hot flashes or cold chills	☐	☐	☐	☐
33	Feeling tired, weak, or easily exhausted	☐	☐	☐	☐
	Column totals				
	Score/Level				

TOTAL SCORE	DEGREE OF ANXIETY
0-4	Minimal or No Anxiety
5-10	Borderline Anxiety
11-20	Mild Anxiety
21-30	Moderate Anxiety
31-50	Severe Anxiety
51-99	Extreme Anxiety or Panic

BURNS DEPRESSION CHECKLIST

Name: _____ Date: _____

	INSTRUCTIONS: Put a check (✓) in the space to the right that best describes how much that symptom or problem has bothered you during this past week.	0 - NOT AT ALL	1 - SOMEWHAT	2 - MODERATELY	3 - A LOT	4 - EXTREMELY
THOUGHTS AND FEELINGS						
1	Feeling sad or down in the dumps	☐	☐	☐	☐	☐
2	Feeling unhappy or blue	☐	☐	☐	☐	☐
3	Crying spells or tearfulness	☐	☐	☐	☐	☐
4	Feeling discouraged	☐	☐	☐	☐	☐
5	Feeling hopeless	☐	☐	☐	☐	☐
6	Low self-esteem	☐	☐	☐	☐	☐
7	Feeling worthless or inadequate	☐	☐	☐	☐	☐
8	Guilt or shame	☐	☐	☐	☐	☐
9	Criticizing yourself or blaming others	☐	☐	☐	☐	☐
10	Difficulty making decisions	☐	☐	☐	☐	☐
ACTIVITIES AND PERSONAL RELATIONSHIPS						
11	Loss of interest in family, friends, colleagues	☐	☐	☐	☐	☐
12	Loneliness	☐	☐	☐	☐	☐
13	Spending less time with family or friends	☐	☐	☐	☐	☐
14	Loss of motivation	☐	☐	☐	☐	☐
15	Loss of interest in work or other activities	☐	☐	☐	☐	☐
16	Avoiding work or other activities	☐	☐	☐	☐	☐
17	Loss of pleasure or satisfaction in life	☐	☐	☐	☐	☐
PHYSICAL SYMPTOMS						
18	Feeling tired	☐	☐	☐	☐	☐
19	Difficulty sleeping or sleeping too much	☐	☐	☐	☐	☐
20	Decreased or increased appetite	☐	☐	☐	☐	☐
21	Loss of interest in sex	☐	☐	☐	☐	☐
22	Worrying about your health	☐	☐	☐	☐	☐
SUICIDAL URGES						
23	Do you have any suicidal thoughts?	☐	☐	☐	☐	☐
24	Would you like to end your life?	☐	☐	☐	☐	☐
25	Do you have a plan for harming yourself?	☐	☐	☐	☐	☐
	Column totals					
	Score/Level					

TOTAL SCORE	LEVEL OF DEPRESSION
0-5	No Depression
6-10	Normal but unhappy
11-25	Mild Depression
26-50	Moderate Depression
51-75	Severe Depression
76-100	Extreme Depression

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+		+
Total				

If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

___Not at all _____Somewhat _____Somewhat Difficult _____Very Difficult _____Extremely Difficult

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Southwestern Oklahoma State University
Center for Health and Well-being

INFORMED CONSENT FOR FACE-TO-FACE AND TELEBEHAVIORAL HEALTH COUNSELING SERVICES

Introduction
Welcome to the Center for Health and Well-being at Southwestern Oklahoma State University. This informed consent document is intended to give you general information about our counseling services. This is a legal document; please read it carefully before signing. If you have any questions about signing this document and/or would like a copy of this document, please ask you counselor.

Eligibility
I understand that eligibility for services is contingent upon my status as an enrolled/continuing SWOSU student or as a current SWOSU employee. SWOSU employees and their dependents also have the option to receive three (3) sessions from an off-campus counseling center annually. (Visit with the staff members for more information).

Confidentiality
Counseling is confidential. Information obtained during counseling sessions will not be disclosed to any outside person(s) or agencies without your written permission, except when required by law. I understand that SWOSU counselors maintain confidentiality in accordance with the ethical guidelines and legal requirements of their profession. Effective counseling sometimes requires that staff members share confidential information with other staff members.

Telebehavioral Health
I have a right to confidentiality with telebehavioral health under the same laws that protect the confidentiality of my medical information for in-person psychotherapy. I further understand that there are risks unique to telebehavioral health, including but not limited to, the possibility that our therapy sessions or other communication by the therapist to others regarding my treatment could be disrupted or distorted by technical failures or could be interrupted or could be accessed by unauthorized persons.

I understand that no records or information about me will be released from the Center for Health and Well-being without my permission, **except under certain circumstances:**

- If I give written permission for the Center for Health and Well-being to discuss a matter with another party.
- If I present a danger to myself or another person.
- If a valid subpoena is issued for my records, or my records are otherwise subject to a court order or other legal process requiring disclosure.
- If I am under the age of 18 and am experiencing abuse, (law requires the reporting of abuse of minors).
- If someone referred you to the Center for Health and Well-Being (e.g., physician, instructor, advisor, RA) and they inquire, may we confirm that you did schedule an appointment?
  ☐ Yes ☐ No ☐ Does Not Apply

Provision of Services

I understand that the Center for Health and Well-being offers a variety of counseling services including intake assessment, various psychological inventories, one session one solution counseling, crisis intervention, flourishing courses, group counseling, telebehavioral health, community resources, and referral to other resources. During the initial assessment, my counselor and I will work together to determine how best to serve my needs. I further understand that appropriate referrals will be provided to me if it is determined that I would be best served by a community resource.

Emergencies
In case of an emergency during office hours, please tell office staff and you can meet with a counselor the same day. **For after-hour emergencies please contact SWOSU Campus Police at (580).774.3111.**

Nature of Counseling
The counseling process is designed to aid individuals who have the capacity to resolve their own problems with some assistance. Most clients seek counseling because they recognize that they need some help in being able to face a certain challenge and/or they find themselves stuck in a dilemma. **Typically, the Center for Health and Well-Being sees clients an average of 4-6 weeks, however, in extenuating circumstances, the process may extend beyond this limit.** As a client, you are in complete control and may end the counseling relationship at any time. Your counselor will respect any such decisions and asks only that you inform them of your plans and resist the tendency to just "not show up anymore". If counseling is successful, you should feel that you are more able to face similar challenges or dilemmas in the future without a counselor's help. In other words, you will have taken some "tools" with you.

Counseling Staff
SWOSU Center for Health and Well-being is staffed with two Licensed Professional Counselors and a Graduate Assistant in Counseling.

Statement of Professional Disclosure
Licensed Professional Counselors in Oklahoma are required by law to furnish this document to you. It requires that they inform you about their professional training, orientation, techniques, experience, fees, and credentials. The Oklahoma State Board of Behavior Health Licensure assigns license numbers to all counselors. Susan Ellis, Licensed Professional Counselor (LPC) #5368, and Kimberly Quintero, Licensed Professional Counselor (LPC) #2042.

The licensing website is https://www.ok.gov/behavioralhealth where you can access the law and regulation, which govern their licenses. Counselors will furnish you with printed materials about the requirements of licensure if you so desire. You may contact (without giving your name), the Professional Counselor Licensing Division at:

State Board of Behavioral Health Licensure (BBHL)
3815 N. Santa Fe, Suite 110
Oklahoma City, OK 73118
Phone: (405). 522.3696
Fax: (405). 522.3691
www.ok.gov/behavioralhealth

Records
Your records are stored electronically and include the information you provided and information about any interactions (individual/group counseling, assessments, phone calls, consultation, emails, etc.) with the Center for Health and Well-being. This information is only accessible within the Center for Health and Well-being and is protected by multiple security measures. This information is separate from your academic records.

Attendance Policy / No Show Policy
We have a very high demand for our services and non-cancelled appointments translate into missed opportunities for other students in need of timely services. If you ***no show*** for your appointment two times, you may lose your privilege of seeing a counselor at the Center for Health and Well-being and will be given several outside referral sources for you to continue your counseling. This policy reflects SWOSU Center for Health and Well-being's desire to benefit as many SWOSU students and employees as possible. Please feel free to clarify this policy with your counselor. *(****No Show*** *is defined as not calling to cancel your appointment or calling to cancel with less than 24 hours' notice. There are a few exceptions such as a last-minute illness or emergency.)*

_____(initials) I agree that while I am seeing a counselor or participating in a group, whenever possible, I will notify the Center for Health and Well-being **at least 24 hours** in advance if I know (or as soon as I know) I will miss a session. I understand that if I do not show for an individual session and do not call, I may lose my standing appointment.

Contact Me
In order to keep my relationship with the Center for Health and Well-being confidential, the best way to contact me should the need arise is noted below. I am aware that an outside party could intercept information exchanged over e-mail.

Okay to Leave a Message	**Please check all that apply**	
Cell Phone: _____	☐ Yes	☐ No
Residential Phone: _____	☐ Yes	☐ No
Work Phone: _____	☐ Yes	☐ No
Other Phones: _____	☐ Yes	☐ No
SWOSU E-mail Address: _____@student.swosu.edu	☐ Yes	☐ No

If there are any concerns with the Center for Health and Well-being that you cannot discuss with your counselor, please contact the Director of Counseling Services or the Vice President for Student Affairs.

Consent for Services
I certify that I have read, understand, and agree to abide by the information outlined above regarding my eligibility and use of the SWOSU Center for Health and Well-being services. I hereby give my consent to authorize the Center for Health and Well-being to evaluate, treat, and/or refer me to additional resources as needed. I have had the opportunity to discuss questions regarding the above information.

_____

Client Signature Date