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 with client		

ACADEMIC/ACREER INFORMATION

Freshman	Sophomore		Junior	Senior	Graduate

Major/Minor	Number of Hours Enrolled	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 for your treatment?

_____

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, vaping, pornography, binge drinking)

_____

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

_____

Are you currently experiencing any chronic pain?

_____

RELATIONAHIPS

Who are the people in your life that you can rely on during tough 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, vaping, 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?

_____

Are you having current suicidal thoughts? When were your last thoughts?

_____

If yes, do you have a plan? Do you have the means to complete your plan!

_____

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

Please describe _____

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

_____

_____

Current or Previous Mental Health Diagnosis:

_____

Current Medications:

_____

Current Medical Doctor/Psychiatrist prescribing medication.

_____

In the PAST TWO WEEKS, I have had problems with:

- ☐ Lower Academic Performance
- ☐ Poor Class Attendance
- ☐ Social Avoidance/Withdrawal
- ☐ Sleep Disturbance
- ☐ Eating/Weight/Body Image
- ☐ Anxiety
- ☐ Social Anxiety
- ☐ Performance Anxiety
- ☐ Test Anxiety
- ☐ Phobias/Extreme Fears
- ☐ Obsessive Thinking
- ☐ Compulsive Behaviors (checking, counting, cleaning)
- ☐ Agitation/Restlessness
- ☐ Decreased Interest/Pleasure

In the COURSE OF MY LIFE, I have had problems with:

- ☐ Adjustment/Transition to College
- ☐ Auditory/Visual Hallucinations
- ☐ Marijuana Abuse
- ☐ Prescription Medi9cation Abuse
- ☐ Stimulant Abuse
- ☐ Opiate Abuse
- ☐ Sedative/Hypnotic/Hallucinogen Abuse
- ☐ Other Drug Abuse
- ☐ Other Addictive Behaviors (gambling, porn, etc.)
- ☐ Grief/Loss
- ☐ Suicidal Thoughts
- ☐ Homicidal Thoughts/Violence
- ☐ University Discipline/Conduct Issues
- ☐ Legal/Arrest/Police Involvement

- ☐ Fatigue/Low Energy
- ☐ Referral by Attorney/Court
- ☐ Depression
- ☐ PTSD/Flashbacks/Nightmares
- ☐ Food Insecurities
- ☐ Financial Issues
- ☐ Childhood abuse (physical, emotional, sexual)
- ☐ 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
- ☐ Self separated or divorced

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

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

THE BURNS ANXIETY INVENTORY

Name:	Date:

	Place a check mark in the box to the right of each category to indicate how much this type of feeling has bothered you in the past several days.	0 = Not at All	1 = Somewhat	2 = Moderately	3 = A Lot
Category I: Anxious Feelings					
1	Anxiety, nervousness, worry or fear	☐	☐	☐	☐
2	Feeling that things around you are strange or unreal	☐	☐	☐	☐
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	☐	☐	☐	☐
Category II: Anxious Thoughts					
7	Difficulty concentrating	☐	☐	☐	☐
8	Racing thoughts	☐	☐	☐	☐
9	Frightening thoughts	☐	☐	☐	☐
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 illnesses or heart attacks or dying	☐	☐	☐	☐
14	Concerns about looking foolish or inadequate	☐	☐	☐	☐
15	Fears of being alone, isolated, or abandoned	☐	☐	☐	☐
16	Fears of criticism or disapproval	☐	☐	☐	☐
17	Fears that something terrible is about to happen	☐	☐	☐	☐
Category III: Physical Symptoms					
18	Skipping, racing or pounding of the heart (palpitations)	☐	☐	☐	☐
19	Pain, pressure, or tightness in chest	☐	☐	☐	☐
20	Tingling or numbness of toes and 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	☐	☐	☐	☐
	Total score for items 1 through 33:				0

Burn's Depression Checklist

Name: Date:

Instructions: Put a check ☑ to indicate how much you have experienced each symptom during the past week, including today. Please answer all 25 items.		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 or 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?					
	Please Total Your Score on Items 1-25 Here:					

Total Score	Level of Depression
No Depression	0-5
Normal but unhappy	6-10
Mild depression	11-25
Moderate depression	26-50
Severe depression	51-75
Extreme depression	76-100

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✓" to indicate your answer)*	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 in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, 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 difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

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PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

ID #: _____ DATE: _____

Over the last *2 weeks,* how often have you been bothered by any of the following problems? *(use "✓" to indicate your answer)*	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 figety 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:				

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

10. If you checked off *any problems,* 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 difficult at all	_____
Somewhat difficult	_____
Very difficult	_____
Extremely difficult	_____

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COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screen Version with Triage Points

SUICIDE IDEATION DEFINITIONS AND PROMPTS:	**Past month**	
Ask questions that are in bolded and underlined	**Yes**	**NO**
Ask Questions 1 and 2		
1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up? ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/commit suicide, "*I've thought about killing myself" without general thoughts of ways to kill oneself/associated methods, intent, or plan.*" ***Have you actually had any thoughts of killing yourself?***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6		
3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it....and I would never go through with it.*" ***Have you been thinking about how you might kill yourself?***		
4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as oppose to "*I have the thoughts but I definitely will not do anything about them.*" ***Have you had these thoughts and had some intention of acting on them?***		
5) Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?***		
6) Suicide Behavior Question ***Have you ever done anything, started to do anything, or prepared to do anything to end your life?*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **If YES, ask:** ***How long ago did you do any of these?*** ☐Over a year ago? ☐Between three months and a year ago? ☐Within the last three months?		

For inquiries and training information contact: Kelly Posner, Ph.D.
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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 your counselor.

Eligibility

I understand that eligibility for counseling services is contingent upon my status as an enrolled/continuing SWOSU student. I must currently be enrolled in at least one hour of classes to be eligible for services.
SWOSU employees and their dependents also have the option to receive three (3) sessions from an off-campus counseling center annually. (Visit SWOSU Human Resources 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.

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 people.

I understand that no records or information about me will be released from the Counseling Center without my permission, **except under certain circumstances:**

- If I give written permission for the Counseling Center 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 required the reporting of abuse of minors).
- If someone referred you to the SWOSU Counseling Center (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 SWOSU offers a variety of counseling services including intake assessment, various psychological inventories, one session one solution counseling, crisis intervention, flourishing courses, group counseling, on-line counseling, 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 immediately. **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 Counseling Center 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 as ask only that you inform him or her 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 Counseling Center is staffed with three Licensed Professional Counselors and a Licensed Alcohol and Drug Counselor.

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 License numbers license all counselors to practice their profession.

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

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 Counseling Center. This information is only accessible within the Counseling Center and is protected by multiple security measures. This information is separate from your academic records.

Attendance Policy / No Show Policy
I agree that while I am seeing a counselor or participating in a group, whenever possible, I will notify the Counseling Center **at least 24 hours** in advance; if 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.

I will contact the Counseling Center as soon as I know I will be unable to make a scheduled appointment. We have an extremely high demand for our services and non-cancelled appointments translate into missed opportunities for other clients in need of timely services. If you *no show** for your appointment two times, you may lose your privilege of seeing a counselor at SWOSU Counseling Center and will be given several outside referral sources for you to continue your counseling. This policy reflects SWOSU Counseling Centers' desire to benefit as many SWOSU students 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.)*

Contact Me
In order to keep my relationship with the Counseling Center 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
SWOSU E-mail Address: _____	☐ Yes ☐ No
Other Phone: _____	☐ Yes ☐ No

If there are any concerns with the Counseling Center 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 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 others as needed. I have had the opportunity to discuss questions regarding the above information.

_____
Client Signature Date

SWOSU CENTER FOR HEALTH AND WELL-BEING INFORMED CONSENT
(Revised 05-08-2025)