



**YORK COUNTY COMMUNITY COLLEGE
COUNSELING
INFORMED CONSENT AGREEMENT**

SERVICES OFFERED: Acute (semester long) Psychotherapy Services, Group Therapy, Referrals. We will discuss other referral and treatment recommendations with you.

MUTUAL RESPECT: The Counselor is committed to respecting those with whom they work and expect students in turn to behave in a respectful manner with the Counselor and any staff. Threatening or abusive language may result in termination of services with a referral to the Dean of Students for follow-up. Physical violence will not be tolerated.

CONFIDENTIALITY: Information shared in counseling sessions will be handled confidentially for all adult clients. The exceptions to the rule of confidentiality include the following:

- 1) If there is reason to believe you might be in imminent danger of harming yourself or others: if so, the appropriate authorities may be contacted (police, administrator, campus security, YCCC BIT Team (Behavioral Intervention Team));
- 2) If there is reason to believe that a child or vulnerable adult has been, or is likely to be, abused or neglected;
- 3) If there is a valid court order which requires disclosure of information; and/or
- 4) You provide written permission to release information.
- 5) You have the opportunity to opt into appointment reminders sent out by the student success coordinator who will know your name and that you attend counseling, but will not have access to other confidential information. If you would like to opt into appointment reminders you agree to the student success coordinator having access to your name and email and being aware that you attend counseling.

I agree and want appointment reminders or

I do not agree and do not want appointment reminders.

RECORDS: Personal data and records of the services you receive will be stored securely. A counselor's notes and any other written information regarding your contact with Counseling are maintained separate and apart from your college academic record. Counseling files are maintained on campus for a fixed period of time after graduation and then destroyed. With your written authorization, counseling information can be disclosed to a third party for the specific purpose stated in your authorization. You may request to review your counseling records by filing a written authorization with Counseling. Your request will be responded to within a reasonable period of time. If Counseling staff believe that review of these records would be detrimental to your health or well-being, Counseling reserves the right to require that a member of Counseling staff be present while you review the file in order to discuss or help interpret information contained in the file.

E-MAIL AND PHONE POLICY: Email is not a secure means to transmit confidential information. Because confidentiality cannot be ensured, and because of our belief in the importance of face-to-face contact, general therapy concerns should be discussed in person with your counselor. However, scheduling appointments can be made by phone and with your consent, by email.

I have read and understood this agreement.

Student Signature: _____

Date: _____

Parent/Guardian: _____

Date: _____

(If under 18 years of age)

Counselor Signature: _____

Date: _____

YORK COUNTY COMMUNITY COLLEGE

COUNSELING

York County Community College

Mental Health Intake Form

The following information is needed to best help you. Please clearly print your response to each question. This will help save time in your first session. If you are unable to complete some parts, then leave them blank and you will have a chance to complete them with your counselor. Case records are strictly confidential.

SECTION I: IDENTIFYING INFORMATION

Date: _____

Last Name: _____ First Name: _____ MI _____

Street Address: _____ Apt or Box #: _____

City _____ State _____ ZIP _____ County _____

Home Phone Number (____) _____ Cell Phone Number (____) _____

_____, email address: _____

Work Phone Number (____) _____ Date of Birth ____/____/____

Gender Male Female, Transgender Self Describe _____

Referred by: Self-Family/Friend School Physician

Marital Status: Never Married Married Divorced Widowed Separated

Other _____

Ethnicity: White/Caucasian African American Hispanic American Indian

Asian/Pacific Islander Other: _____

Employment Status: Full time Part time Unemployed/looking for work Student Retired

Disabled Other: _____

Emergency Contact: _____

Relationship to Client: _____ Phone: _____

YORK COUNTY COMMUNITY COLLEGE

COUNSELING

SECTION II: FAMILY/HOME INFORMATION

How many dependents do you have? (Include yourself) _____

Children

Age

Living at Home?

List other people living in the home besides those named above:

Name

Age

Relationship

Are your parents divorced? Yes____ No____

Have any members of your family had problems with: Drugs____ Alcohol____ Mental Illness____

SECTION III: DESCRIPTION OF PRESENTING PROBLEM

Briefly describe the problem that brings you to counseling services today:

How can we help you with this, what do you want to work on in counseling and change?

How long has it been a significant problem?

In the past, what has been helpful to you in dealing with this problem?

YORK COUNTY COMMUNITY COLLEGE

COUNSELING

How would you estimate the severity of the problem: Mild___ Moderate ___ Serious_ Severe___ ?

SECTION IV: MEDICAL/HEALTH INFORMATION

Treatment History:

Have you received mental health treatment before? Yes No

Have you been in therapy before or received any prior professional assistance for your concerns? If so, please give dates of treatments and results:

Therapist/Hospital	Dates	Phone	Initial Reason	Outcome
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Please check any of the following that you have experienced recently:

- | | | | |
|-----------------------------------------------|---------------------------------------------|--------------------------------------------|-------------------------------------|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Voices/visions | <input type="checkbox"/> Suicide |
| <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Running away | <input type="checkbox"/> Appetite problems | <input type="checkbox"/> Stealing |
| <input type="checkbox"/> Compulsive behaviors | <input type="checkbox"/> Weight loss/gain | <input type="checkbox"/> Racing thoughts | <input type="checkbox"/> Paranoia |
| <input type="checkbox"/> Sleep problems | <input type="checkbox"/> Too much energy | <input type="checkbox"/> Poor attention | <input type="checkbox"/> Anger |
| <input type="checkbox"/> Social Withdrawal | <input type="checkbox"/> Distractibility | <input type="checkbox"/> Irritability | <input type="checkbox"/> Low energy |
| <input type="checkbox"/> Aggression/violence | <input type="checkbox"/> Poor concentration | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Blackouts |
| <input type="checkbox"/> Memory problems | <input type="checkbox"/> other(s) _____ | | |

YORK COUNTY COMMUNITY COLLEGE

COUNSELING

It is very important for your counseling treatment that we are able to have contact with your primary care provider (PCP). Do you give your permission for us to contact your PCP? Yes No

If you decline, please provide specific information for your denial:

Who is your primary doctor/medical provider?

Name	City	Phone number
------	------	--------------

What medications do you take? (Include non-prescription, herbal medicines and supplements)

Medicine	Dose	Frequency	Who prescribes
----------	------	-----------	----------------

Please list any allergies, including medication allergies/sensitivities:

Date of your last exam: _____

Please list any significant health or medical or psychiatric issues, including any resulting in hospitalization

<u>Dates</u>	<u>Problem and Treatment</u>	<u>Were you hospitalized Y/N</u>
--------------	------------------------------	----------------------------------

YORK COUNTY COMMUNITY COLLEGE

COUNSELING

Suicide Attempt/s or Violent Behavior:

Age	Reason	Circumstance	How

Abuse/Trauma History: I was not abused in any way I was abused

If you were abused, please complete this section. . To describe the type of abuse, use these letters: P = Physical, such as beatings. S = Sexual, such as touching/molesting, fondling, or intercourse. N = Neglect, such as failure to feed, shelter, or protect you. E = Emotional, such as humiliation.

Your age	Kind of abuse	By whom?	Effects on you?	Whom did you tell?	Consequences of telling?

Substance Use:

Have you been treated for alcohol/drug problems before? Yes No

If so, when and where _____

Check any of the following that apply to you:

	Never	Rarely	Frequently	Very Often
Marijuana	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tranquilizers, benzo's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sedatives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine/crack/ecstasy/bath salt/Meth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

YORK COUNTY COMMUNITY COLLEGE

COUNSELING

	Never	Rarely	Frequently	Very Often
Painkillers, oxys, opiates	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heroin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cigarettes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stimulants Adderall	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinogens LSD/Mushroom /PCP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Compulsive Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use Laxatives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heroin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inhalants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Synthetic Cannabis (spice)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleeping pills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle Relaxer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Alcohol Use:

Have you ever felt the need to cut down on your drinking? No Yes

Have you ever felt annoyed by criticism of your drinking? No Yes

Have you ever felt guilty about your drinking? No Yes

Have you ever taken a morning "eye-opener"? No Yes

How much beer, wine, or hard liquor do you consume each week, on average?

How much tobacco do you smoke or chew each day?

YORK COUNTY COMMUNITY COLLEGE

COUNSELING

Describe any problems associated with these substances that you have experienced.

How much time outside of academic work do you spend on the internet per day?

SECTION V: SOCIAL RELATIONSHIP STATUS

Among friends and family who do you depend on for support?

Are you: Single ___ Dating ___ Married/Partnered ___ Divorced/unpartnered ___ Widowed/ a surviving partner ___

Friendships, Community and Spirituality – describe quality, frequency, activities

Are you involved in any current or pending civil or criminal litigation/s, lawsuit/s, or divorce/custody disputes? If yes, please explain:

What gives you the most joy or pleasure in your life?

What are your main worries and fears?

YORK COUNTY COMMUNITY COLLEGE

COUNSELING

What are your most important hopes and dreams?

Is there anything else we need to know to assist you?

York County Community College, Student Counseling Services
112 College Drive, Wells, Maine 04090

Name: _____

Address: _____

Telephone: _____

DOB: _____

YORK COUNTY COMMUNITY COLLEGE

COUNSELING

AUTHORIZATION TO RELEASE AND/OR OBTAIN INFORMATION

I hereby authorize, by my initials, YCCC Counseling, or its authorized employees or agents, to release and/or obtain the following specified information by means other than Fax. I understand that my Counseling records may contain reference to sensitive or statutorily protected information that will not be released unless I authorize the release of each category:

_____ mental/emotional health, including antidepressant medications
_____ abortion _____ sexual abuse/assault _____ sexual preference
_____ drug/alcohol abuse _____ HIV/AIDS

I hereby authorize the above initialed information to be released to and/or obtained from the following:

Release to: _____ *and/or* Obtain from: _____

Name or Facility _____

Address _____

City/State/Zip _____

Specified Information to Release _____

The purpose of this release is to:

I understand that I may refuse to authorize disclosure of all or some my counseling information and records, and that refusal may result in improper diagnosis or treatment, denial of coverage or a claim for health benefits or other insurance and/or other adverse consequences. I agree to release and hold harmless the Maine Community College System and York County Community College, and their respective officers, employees and agents harmless from any injury, claims and damages that may arise as the result of the release or acquisition of my counseling information and records. This Disclosure Authorization will expire six months from the date of signing, unless otherwise specified herein. I understand that I can revoke this consent at any time before the expiration date by notifying Counseling Services in writing, except to the extent that action has been taken in reliance on my consent. I further understand that if I revoke my consent, such revocation may be the basis for denial of counseling benefits or other insurance coverage or benefits. I understand that I am entitled to a copy of this authorization form.

Signature: _____ **Date:** _____

_____ **With my initials, I acknowledge receipt of a copy of this form.**

Parent/Guardian: _____ **Date:** _____

(If under 18 years of age)

RE-RELEASE OF CONFIDENTIAL COUNSELING INFORMATION BY RECIPIENTS IS PROHIBITED UNLESS AUTHORIZED IN WRITING BY THE CLIENT.