

Counseling & Mental Health Services (CMHS)
HEALTH SERVICES ANNEX
234 Glenbrook Road, Unit 2011
Storrs, CT 06269-2011

Telephone: 860.486.4705 Website: www.cmhs.uconn.edu

INITIAL ASSESSMENT: *This first meeting is an assessment to determine how our services will be most helpful to you. Treatment plans are individualized for your specific needs and concerns. After completing the initial assessment, your therapist may recommend one or more of the following services:*

- *Brief crisis intervention (1 or 2 sessions to address immediate crisis)*
- *Individual therapy for further evaluation and psychotherapy*
- *Group therapy*
- *A medication evaluation with a psychiatrist or psychiatric nurse practitioner (APRN)*
- *Resources elsewhere if our services are not appropriate or best suited for you*

DURATION OF TREATMENT: *The University provides 1 to 8 sessions per academic year. The goal of brief treatment is to focus on current concerns and to promote further individual growth and to help relieve some of the emotional discomfort. There is no limit for group therapy or psychiatrist/APRN sessions. A referral list will be given when long-term treatment is indicated or requested.*

EMERGENCY SERVICES AFTER HOURS: *After 4:30 p.m. on weekdays and from 8:00 a.m.-Saturdays through 8:30 am Mondays call 860-486-4705.*

IN ANY MENTAL HEALTH EMERGENCY, CALL 911

OUR STAFF: *CMHS therapists are licensed psychiatrists, counseling and clinical psychologists, clinical social workers, advanced practice registered nurses (APRN), administrative professionals, as well as advanced graduate students in clinical psychology and clinical social work who work under direct supervision of our licensed clinical staff.*

CONFIDENTIALITY: *All contacts with Student Health Services/Counseling & Mental Health Services are strictly confidential in accordance with HIPAA regulations. Records are not available to individuals or agencies either on or off campus, without a student's specific written permission. CMHS records are kept separately from medical records, but are available to SHS providers on a need-to-know basis. Copies of psychiatric medication prescriptions, laboratory reports, and a notation that there is a CMHS record are in the Student Health Services medical record. By law and by professional codes of ethics, confidentiality is only broken by a therapist when: 1) the student is in imminent danger of harm to self or others, 2) a therapist suspects abuse or neglect of a child under the age of 18, or 3) a court orders a record. Even in these cases, we will try our best to work with the student in communicating this information to other parties. In accordance with State of Connecticut record retention schedules, CMHS record is destroyed after seven years.*

SERVICE FEES: *Initial assessment.....\$ 0 Individual Therapy.....\$10 Medication Evaluation....\$20
Group Therapy.....\$ 5 Medication Monitoring...\$10*

*Service fees may be billed as "HS Misc." on your University fee bill or can be paid by cash/check at the time of your appointment. **Service fees are not reimbursable by any insurance.***

PLEASE NOTE: *There is a \$15 charge if you do not show for your scheduled appointment or cancel/reschedule less than 24 hours in advance.*

My signature below indicates that I have read and understood the information sheet, and that I agree to the clinic's policies on treatment, confidentiality, and billing.

Signature: _____ **Date:** ____/____/____

Name: _____ **Birthdate:** ____/____/____ **Age:** _____

Counseling & Mental Health Service

Signature: _____ Date: ____/____/____

Name: _____ Birthdate: ____/____/____ Age: _____
(Print)

Gender: M ___ F ___ SSN: ____ - ____ - ____ Peoplesoft #: _____

Local Address:

Street/Dormitory Room #: _____

City _____ State _____ Zip Code _____

Local Telephone: _____ Cell #: (____) _____

Permanent Address: _____ Telephone #: (____) _____

Street: _____

City _____ State _____ Zip Code _____

Emergency Contact: _____

(name) (relationship)

(____) (____)
(work phone) (home phone)

Are you an international student? Y N If yes, from what country? _____

Are you employed? Y N If yes, number of hours per week: _____

Who referred you? Self ___ Parent ___ Dean of Students ___ Court Referral _____

RA ___ Friend ___ Health Service ___ Other? _____

Academic Information: Undergraduate ___ Semester Standing _____ Graduate ___ Non-degree ___

Full-time ___ Part-time ___ Academic Probation? Y N

Major: _____ GPA _____

Vocational Objectives: _____

Extracurricular interests/activities: _____

Relationship Status: Single _____ Divorced _____ Involved-how long? _____
Widowed ___ Separated _____ Married- how long? _____

Counseling & Mental Health Services

FAMILY INFORMATION

Spouse: _____ Age: _____ Occupation: _____

Children's names and ages:

_____, _____, _____, _____

Religious preference: Yours _____ Father _____ Mother _____

Country of origin: Yours _____ Father _____ Mother _____

Parents' marriage: (year) _____ Divorce (year) _____

If remarried, year: Father _____ Mother _____

	NAME	AGE	EDUCATION	OCCUPATION
		(If deceased, give date)		
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Stepfather	_____	_____	_____	_____
Stepmother	_____	_____	_____	_____
Siblings	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

MEDICAL INFORMATION

• Do you have health insurance? (circle one) YES NO

• Have you had any serious illnesses? (circle one) YES NO

If yes, please specify. _____

• Are you presently under medical care? (circle one) YES NO

If yes, please specify the reason and the physician's name. _____

• Are you presently taking any medications? (circle one) YES NO

If yes, please specify the medication and dosage. Include oral contraceptives and allergy medications.

Counseling & Mental Health Services

MEDICAL INFORMATION, cont.

- Have you ever been hospitalized for medical reasons? (circle one) YES NO

Explain: _____

- List any allergies you have, including allergic reactions to medications:

_____, _____, _____, _____, _____

- Do you smoke cigarettes? (circle one) YES NO If so, how much? _____

- Has anyone in your family ever been treated for emotional problems? (circle one) YES NO

If yes, who? _____

When? _____

Type of problem? _____

- Do you or any members of your family abuse (or in the past abused) alcohol, drugs or other substances? (circle one) YES NO

If yes, who? _____

What substances? _____

- Have you ever had any counseling or therapy (individual or group)? (circle one) YES NO

If yes, where and dates: _____

- Have you ever been hospitalized for psychiatric reasons? (circle one) YES NO

If yes, where? _____

When? _____

Reason: _____

- Why have you come to Counseling & Mental Health Services?

Counseling & Mental Health Services

AUDIT QUESTIONNAIRE

1. How often do you have a drink containing alcohol?

- Never Monthly or less Two to Four times a month Two to three times a week
 Four or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?

- 1 or 2 3 or 4 5 or 6 7 to 9 10 or more

3. How often during the last year have you found that you were not able to stop drinking once you started?

- Never Less than monthly Monthly Weekly Daily or almost daily

4. How often during the last year have you been unable to remember what happened when you had been drinking?

- Never Less than monthly Monthly Weekly Daily or almost daily

5. Have you ever had conflicts with peers, authorities or other problems when drinking?

- Yes No

Explain: _____

6. Have you used any illicit drugs in the past twelve months or misused prescription medications?

- Yes No

If yes, drug name _____

Frequency of use _____

Counseling and Mental Health Services

Name _____ Gender _____ Age _____ Date _____

This is a list of problems people sometimes have. For each item, circle in the **Current** column the number that best describes how much that problem has distressed you in the past month. Then, check the **Past** column if you have previously experienced that problem.

0 - NOT AT ALL 1 - A LITTLE BIT 2 - MODERATELY 3 - QUITE A BIT 4 - EXTREMELY

PAST	CURRENT		PAST	CURRENT	
___	0 1 2 3 4	Depression	___	0 1 2 3 4	Bingeing and/or overeating
___	0 1 2 3 4	Feeling empty frequently	___	0 1 2 3 4	Feeling fat
___	0 1 2 3 4	Feeling hopeless	___	0 1 2 3 4	Induced vomiting
___	0 1 2 3 4	Feeling isolated	___	0 1 2 3 4	Self-starvation
___	0 1 2 3 4	Uncontrolled crying	___	0 1 2 3 4	Excessive exercise
___	0 1 2 3 4	Distressing mood changes	___	0 1 2 3 4	Laxative abuse
___	0 1 2 3 4	Suicidal thoughts			
___	0 1 2 3 4	Feeling guilty	___	0 1 2 3 4	Difficulty being assertive
___	0 1 2 3 4	Feeling abandoned	___	0 1 2 3 4	Shyness
___	0 1 2 3 4	Self-injury	___	0 1 2 3 4	Peer relationship problem
			___	0 1 2 3 4	Jealousy
___	0 1 2 3 4	Feeling overwhelmed	___	0 1 2 3 4	Overcontrolled by parents
___	0 1 2 3 4	Difficulty concentrating	___	0 1 2 3 4	Difficulty with authority figures
___	0 1 2 3 4	Sleep problems	___	0 1 2 3 4	Family relationship problems
___	0 1 2 3 4	Change in appetite	___	0 1 2 3 4	Concerns about leaving home
___	0 1 2 3 4	Nightmares	___	0 1 2 3 4	Feeling persecuted
			___	0 1 2 3 4	Romantic relationship problems
___	0 1 2 3 4	Racing heart			
___	0 1 2 3 4	Excessive worrying	___	0 1 2 3 4	Losing temper easily
___	0 1 2 3 4	Anxiety	___	0 1 2 3 4	Unprovoked anger
___	0 1 2 3 4	Panic attacks	___	0 1 2 3 4	Verbal/physical abuse to others
___	0 1 2 3 4	Feeling tense			
___	0 1 2 3 4	Shaking and/or sweating	___	0 1 2 3 4	Academic difficulty
___	0 1 2 3 4	Nausea	___	0 1 2 3 4	Concerns about leaving school
___	0 1 2 3 4	Gastro-intestinal distress	___	0 1 2 3 4	Difficulty making career or academic/major decisions
___	0 1 2 3 4	Compulsions and/or obsessions			
___	0 1 2 3 4	Headaches	___	0 1 2 3 4	Financial problems
___	0 1 2 3 4	Specific fears or phobias			
			___	0 1 2 3 4	Coming out issues
___	0 1 2 3 4	Hyperactivity	___	0 1 2 3 4	Sexual orientation concerns
___	0 1 2 3 4	Excessive energy, spending sprees, or hypersexuality	___	0 1 2 3 4	Sexual problems or concerns
___	0 1 2 3 4	Decreased need for sleep	___	0 1 2 3 4	Physical or sexual assault
___	0 1 2 3 4	Strange or bizarre thoughts	___	0 1 2 3 4	Major traumatic event
			___	0 1 2 3 4	Racial or sexual harassment
			___	0 1 2 3 4	Death of close friend or relative
___	0 1 2 3 4	Drug or alcohol problems	___	0 1 2 3 4	Unwanted pregnancy
___	0 1 2 3 4	Arrest or student discipline	___	0 1 2 3 4	Incest or childhood molestation