Le Moyne College

- CONFIDENTIAL -

Intake Information Form

Date: _____ Name: _____

Class Year: Freshman _____ Sophomore _____ Junior _____ Senior _____ Graduate _____

Are you a Transfer Student? Yes _____ No _____

Local/Campus Address: _____

Best way to contact you if necessary: Cell Phone _____ E-mail _____

Phone #: _____ E-Mail Address: _____

Referred by: _____ Administrator/Staff _____ Faculty _____ Campus Ministry

_____ Academic Advising _____ Judicial _____ Residence Life

_____ Famly Member _____ Peer _____ Self _____ Other

Are you currently taking any medications? Yes _____ No _____

Are you currently taking any supplements? Yes _____ No _____

If "Yes," please list: _____

_____

_____

Other medical issues/concerns? Yes _____ No _____

If "Yes," please list: _____

_____

_____

Person(s) to Contact in Case of Emergency: _____

Relationship: _____ Phone Number(s): _____

Insurance Company: _____ Policy #: _____

Types of Concerns: Check all that apply to you.

_____ Academic Difficulties
_____ Anxiety/Nervous
_____ Career Concerns
_____ Eating Concerns
_____ Family Concerns/Problems
_____ Grief/Loss
_____ Panic Attacks
_____ Physical/Medical
_____ Relationship (Friend/Roommate)
_____ Relationship (Love/Sexual)
_____ Sad/Unhappy/Depressed
_____ Self-Abuse/Cutting
_____ Sexual Identity Concerns
_____ Sleep Disturbances
_____ Suicidal Feelings
_____ Substance Use (Alcohol/Drugs)
_____ Tense/Stressed
_____ Test Anxiety
_____ Trauma or Assault
_____ Other

Le Moyne College
WELLNESS CENTER for HEALTH and COUNSELING

The primary mission of the Wellness Center for Health and Counseling at Le Moyne College is to enhance the educational experience by promoting wellness of mind-body-spirit and to empower students within the college community to make informed and intentional choices regarding their overall health and well-being. We provide exceptional care to the whole student through an integrated model of service delivery.

Consent for Treatment and Explanation of Policies

The Wellness Center for Health and Counseling strictly protects the privacy of information related to your physical and emotional health, and any care you receive at our center. In order to provide the best possible treatment, your provider may consult with other professionals **within** the Health and Counseling Center about issues directly related to your treatment.

Any information that is part of your records at the Health and Counseling Center will be protected and confidential. This record is completely separate from your academic record. There are some important legally mandated exceptions to confidentiality. These include:

- Threat of immediate danger to self or others (e.g., suicide or homicide)
- Reportable conditions diagnosed by Health Services, such as meningitis and sexually transmitted infections which constitute public health risks
- Any incidence of suspected elder, dependent adult or child abuse, neglect, or maltreatment in order to protect the individuals involved
- In rare circumstances, providers or clinical records may be subpoenaed by the court in legal cases

*In the event of an **emergency**, information needed to provide appropriate treatment may be disclosed.* Otherwise, confidential information will not be disclosed without your written authorization to do so.

E-mail may not be a secure or reliable means of communication. Therefore, confidentiality cannot be guaranteed. Provide an e-mail address if you agree that we can use e-mail to communicate with you.

On occasion clients may find themselves working alongside one of their treatment providers as part of a college activity. In these situations the Health and Counseling providers take caution to protect clients' privacy and do not reveal whether any client has received services at our Center.

The Wellness Center for Health and Counseling is a training site for mental health professionals. As such, you may be seen by a counselor in training. In such cases, you will be notified of your provider's trainee status and the name of their supervisor. Questions regarding your care can be directed to the supervisor of the provider you are seeing and/or the Health and Counseling Center Director. The Wellness Center employs college work study students, who also take an oath of confidentiality.

I have read and understand the Consent for Treatment and Explanation of Policies and the Notice of Privacy Practices and am satisfied by the explanations. I agree to show up (or cancel with 24 hr. notice) for scheduled appointments; failure to do so may result in being placed on a waiting list for services. In the event of an emergency, Health and Counseling Center staff may contact any persons who can help facilitate my care (e.g., other professionals, referral sources, family or friends identified as potential resources). If I have any questions about my rights, responsibilities, privacy and/or the operation of the Wellness Center for Health and Counseling, I may ask my provider.

Authorizing Signature
I understand the above-stated policies and I consent to treatment at the Wellness Center for Health and Counseling at Le Moyne College. I acknowledge that I may withdraw this consent at any time.

Signature _____ Date _____

Please help us understand how much the problem which brings you to the Counseling Center interferes with your functioning:

1. Has your problem or difficulty affected your class attendance?

Yes____ No____

2. Has your problem or difficulty affected your ability to concentrate on the lecture or other classroom activity?

Yes____ No____

3. Has your problem or difficulty affected your ability to get reading done, and to complete assignments outside of class?

Yes____ No____

4. Has your problem or difficulty affected your ability to perform up to your ability on tests?

Yes____ No____

5. How much would you say that your current problem or difficulty affects your ability to pursue your education at Le Moyne? (circle one number)

1	2	3	4	5	6	7
Not Very Much			A Moderate Amount			Very Much

6. Please rate the severity of your current problem or difficulty.

1	2	3	4	5	6	7
Not Very Severe			Moderately Severe			Very Severe

Beck Anxiety Inventory

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by that symptom during the past month, including today, by circling the number in the corresponding space in the column next to each symptom.

	Not at All	Mildly – but it didn't bother me much.	Moderately – it wasn't pleasant at times.	Severely – it bothered me a lot.
Numbness or Tingling	0	1	2	3
Feeling Hot	0	1	2	3
Wobbliness in Legs	0	1	2	3
Unable to Relax	0	1	2	3
Fear of Worst Happening	0	1	2	3
Dizzy or Lightheaded	0	1	2	3
Heart Pounding or Racing	0	1	2	3
Unsteady	0	1	2	3
Terrified or Afraid	0	1	2	3
Nervous	0	1	2	3
Feeling of Choking	0	1	2	3
Hands Trembling	0	1	2	3
Shaky/unsteady	0	1	2	3
Fear of Losing Control	0	1	2	3
Difficulty in Breathing	0	1	2	3
Fear of Dying	0	1	2	3
Scared	0	1	2	3
Indigestion	0	1	2	3
Faint / Lightheaded	0	1	2	3
Face Flushed	0	1	2	3
Hot / Cold Sweats	0	1	2	3
Column Sum	0			

Scoring – Sum each column. Then sum the column totals to achieve a grand score.

Write that score here _____.

Beck Depression Inventory

1.	0	I do not feel sad.
	1	I feel sad.
	2	I am sad all the time and can't snap out of it.
	3	I am so sad or unhappy that I can't stand it.
2.	0	I am not particularly discouraged about the future.
	1	I feel discouraged about the future.
	2	I feel I have nothing to look forward to.
	3	I feel that the future is hopeless and that things cannot improve.
3.	0	I do not feel like a failure.
	1	I feel I have failed more than the average person.
	2	As I look back on my life, all I can see is a lot of failures.
	3	I feel I am a complete failure as a person.
4.	0	I get as much satisfaction out of things as I used to.
	1	I don't enjoy things the way I used to.
	2	I don't get real satisfaction out of anything anymore.
	3	I am dissatisfied or bored with anything.
5.	0	I don't feel particularly guilty.
	1	I feel guilty a good part of the time.
	2	I feel quite guilty most of the time.
	3	I feel guilty all of the time.
6.	0	I don't feel I am being punished.
	1	I feel I may be punished.
	2	I expect to be punished.
	3	I feel I am being punished.
7.	0	I don't feel disappointed in myself.
	1	I am disappointed in myself.
	2	I am disgusted with myself.
	3	I hate myself.
8.	0	I don't feel I am worse than anybody else.
	1	I am critical of myself for my weaknesses or mistakes.
	2	I blame myself all the time for my faults.
	3	I blame myself for everything bad that happens.
9.	0	I don't have any thoughts of killing myself.
	1	I have thoughts of killing myself, but I would not carry them out
	2	I would like to kill myself.
	3	I would kill myself if I had the chance.
10.	0	I don't cry any more than usual.
	1	I cry more now than I used to.
	2	I cry all the time now.
	3	I used to be able to cry, but now I can't even cry even though I want to.
11.	0	I am no more irritated by things than I ever am.
	1	I am slightly more irritated now than usual.
	2	I am quite annoyed or irritated a good deal of the time.
	3	I feel irritated all the time now.

Beck Depression Inventory (Continued)

12. 0 I have not lost interest in other people.
    1 I am less interested in other people than I used to be.
    2 I have lost most of my interest in other people.
    3 I have lost all of my interest in other people.

13. 0 I make decisions about as well as I ever could.
    1 I put off making decisions more than I used to.
    2 I have greater difficulty in making decisions than before.
    3 I can't make decisions at all anymore.

14. 0 I don't feel that I look any worse than I used to.
    1 I am worried that I am looking old or unattractive.
    2 I feel that there are permanent changes in my appearance that make me look unattractive.
    3 I believe that I look ugly.

15. 0 I can work about as well as before.
    1 It takes an extra effort to get started at doing something.
    2 I have to push myself very hard to do anything.
    3 I can't do any work at all.

16. 0 I can sleep as well as usual.
    1 I don't sleep as well as I used to.
    2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
    3 I wake up several hours earlier than I used to and cannot get back to sleep.

17. 0 I don't get tired more than usual.
    1 I get tired more easily than I used to.
    2 I get tired from doing almost anything.
    3 I am too tired to do anything.

18. 0 My appetite is no worse than usual.
    1 My appetite is not as good as it used to be.
    2 My appetite is much worse now.
    3 I have no appetite at all anymore.

19. 0 I haven't lost much weight, if any, lately.
    1 I have lost more than five pounds.
    2 I have lost more than ten pounds.
    3 I have lost more than fifteen pounds.

20. 0 I am no more worried about my health than usual.
    1 I am worried about physical problems such as aches or pains, or upset stomach, or constipation.
    2 I am very worried about physical problems and it's hard to think of much else.
    3 I am so worried about my physical problems that I cannot think about anything else.

21. 0 I have not noticed any recent change in my interest in sex.
    1 I am less interested in sex than I used to be.
    2 I am much less interested in sex now.
    3 I have lost interest in sex completely.

Depressive Symptom Index – Suicidality Subscale

Instructions: On this questionnaire are groups of statements. Please read all of the statements in a given group. Pick out and circle the one statement in each group that describes you best for the past *two weeks*. If several statements in a group seem to apply to you, pick the one with the higher number. *Be sure to read all of the statements in each group before making your choice*.

(A) 0 I do not have thoughts of killing myself.
1 Sometimes I have thoughts of killing myself.
2 Most of the time I have thoughts of killing myself.
3 I always have thoughts of killing myself.

(B) 0 I am not having thoughts about suicide.
1 I am having thoughts about suicide but have not formulated any plans.
2 I am having thoughts about suicide and am considering possible ways.
3 I am having thoughts about suicide and have formulated a definite plan.

(C) 0 I am not having thoughts about suicide.
1 I am having thoughts about suicide but have the thoughts completely under control.
2 I am having thoughts about suicide the have the thoughts somewhat under control.
3 I am having thoughts about suicide but have little or no control over the thoughts.

(D) 0 I am not having impulses to kill myself.
1 In some situations I have impulses to kill myself.
2 In most situations I have impulses to kill myself.
3 In all situations I have impulses to kill myself.

Alcohol Use

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

Never (0)
Monthly or less (1)
Two to four times a month (2)
Two to three times a week (3)
Four or more times a week (4)

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

1 or 2 (0)
3 or 4 (1)
5 or 6 (2)
7 to 9 (3)
10 or more (4)

3. How often do you have six or more drinks on one occasion?

Never (0)
Less than monthly (1)
Monthly (2)
Weekly (3)
Daily or almost daily (4)

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

Never (0)
Less than monthly (1)
Monthly (2)
Weekly (3)
Daily or almost daily (4)

5. How often during the last year have you failed to do what was normally expected of you because of drinking?

Never (0)
Less than monthly (1)
Monthly (2)
Weekly (3)
Daily or almost daily (4)

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

Never (0)
Less than monthly (1)
Monthly (2)
Weekly (3)
Daily or almost daily (4)

7. How often during the last year have you had a feeling of guilt or remorse after drinking?

Never (0)
Less than monthly (1)
Monthly (2)
Weekly (3)
Daily or almost daily (4)

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

Never (0)
Less than monthly (1)
Monthly (2)
Weekly (3)
Daily or almost daily (4)

9. Have you or someelse been injured as a result of your drinking?

No (0)
Yes, but not in the last year (2)
Yes, during the last year (4)

10. Has a relative or friend, doctor or other healthcare worker been concerned about your drinking, or suggested you cut down?

No (0)
Yes, but not in the last year (2)
Yes, during the last year (4)

DO YOU HAVE A PROBLEM WITH SMOKING?

YES	NO	
____	____	Do you look forward to smoking?
____	____	Do you smoke more and more as time goes by?
____	____	Have friends or family members asked you to stop smoking around them?
____	____	Do you get upset when you are asked not to smoke?
____	____	Do you ever hide your use from other people?
____	____	Have you tried to quit, but can't?
____	____	Do you take smoke breaks between classes or at work?
____	____	Do you get short of breath when you walk up a flight of stairs?
____	____	Are you unconcerned about health risks such as heart disease or lung cancer?
____	____	Have you noticed a reduced sense of taste or smell?
____	____	Have you noticed that your heart beats faster when you smoke?
____	____	Have you been getting more colds and flus lately?
____	____	Has your doctor told you your blood pressure has increased?

The "SCOFF" Questions:

Do you make yourself sick (vomit) because you feel uncomfortably full?	Yes	No
Do you worry that you have lost control over how much you eat?	Yes	No
Have you recently lost more than 14 pounds in a 3-month period?	Yes	No
Do you believe yourself to be fat when others say you are thin?	Yes	No
Would you say that food dominates your life?	Yes	No

Marijuana Use

YES	NO	
____	____	Do you use marijuana? If No, then skip to the next section (Self-Injury).
____	____	Are you using marijuana more and more often?
____	____	Do you think marijuana is safe and that it's not addictive?
____	____	Do you use marijuana to escape from problems or to relax?
____	____	Do you seek out people to you can smoke marijuana with them?
____	____	Do you do things under the influence of marijuana that you wouldn't normally do?
____	____	Do you worry that you'll run out of marijuana?
____	____	Do you think marijuana makes you more creative and social?
____	____	Does your throat ever feel raspy?
____	____	Are you finding it more difficult to remember things that recently happened?
____	____	Have you noticed you react more slowly to situations, even if they're serious?
____	____	Do you feel tired more often?
____	____	Do you find you're getting more colds, flus, or other infections?

Self-Injury

Have you ever engaged in any of the following self-harm behaviors during your life? Please estimate the number of times for each:

Cutting _____	Severe Scratching _____	Biting _____	Rubbing Skin Against Rough Surface _____
Burning _____	Banging or Hitting Self _____	Carving _____	Interfering w/Wound Healing (i.e., picking scabs) _____
Pinching _____	Sticking Self w/Needles _____	Pulling Out Hair _____	Swallowing Dangerous Substances _____

Other _____