University of Kansas Medical Center
STUDENT/RESIDENT COUNSELING SERVICES

Counseling & Educational Support Services

In order to provide you with counseling services that you have requested, please complete the following questionnaire as thoroughly as possible. Your completed questionnaire will become part of your counseling record.

Name (please print): _____ **Date of birth:** _____

Local address: _____

Mobile phone: _____

Referral Information

Referred by:

☐ self
☐ friend
☐ academic advisor
☐ parent/ family member
☐ professor/ TA
☐ dean
☐ student health/ medical provider

Additional Demographics

Please answer the following questions:

Are you a parent? ☐ yes ☐ no
Are you a single parent? ☐ yes ☐ no
Are you currently in any branch of the military? ☐ yes ☐ no
Are you a veteran? ☐ yes ☐ no
Are you a first generation college student? ☐ yes ☐ no
What was your place of birth? _____

Ethnicity

Check all that apply

☐ African / African American
☐ Chinese / Chinese American
☐ Filipino/ Filipino American
☐ Korean / Korean American
☐ Vietnamese / Vietnamese American
☐ Mexican/ Mexican American/ Chicano
☐ Other Asian
☐ Other Latino / Spanish American
☐ Other Hispanic
☐ American Indian/ Alaska Native
☐ East Indian / Pakistani
☐ Japanese / Japanese American
☐ Pacific Islander
☐ Middle Eastern
☐ White / Caucasian
☐ Prefer to not answer

How do you describe your ethnicity?: _____
_____
_____

Disabilities

Do you currently have a diagnosed disability? ☐ yes ☐ no
If yes, please specify: _____

Are you currently registered with KUMC's Academic Accommodation Services? ☐ yes ☐ n

Academic/ Employment Information

Overall GPA: _____

Are you experiencing current academic difficulties? ☐ yes ☐ no

- If yes, are any of these applicable?
  ☐ academic or residency probation ☐ subject to dismissal ☐ dismissed
- Other type of academic issue, if applicable: _____

_____

Are you currently employed? ☐ yes, on campus ☐ yes, off campus ☐ no

- If yes, how many hours per week do you work? _____

Presenting Concerns

What are your primary concerns? _____

_____

_____

How long have your concerns been bothering you?

☐ for one past day ☐ for one past week ☐ for one past month
☐ for six months ☐ for one past year ☐ for more than a year

Intensity of Concern

	1 (low)				*5 (high)*
Please rate your current distress regarding this/ these concerns:	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
How much are your concerns interference with:					
• Social relationships/ activities	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
• Emotional well-being	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
• Daily routine	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Gender/Sexual Identity/ Sexuality

What was your sex at birth?

☐ male
☐ female
☐ intersex
☐ prefer to not answer

What is your gender identity?

☐ cisgender (non-transgender) man
☐ cisgender (non-transgender) woman
☐ genderqueer
☐ nongender
☐ questioning or unsure
☐ transgender man
☐ two-spirit
☐ prefer to not answer

Self identify: _____

What is your sexual orientation?

☐ asexual
☐ bisexual
☐ gay
☐ heterosexual
☐ lesbian
☐ pansexual
☐ queer
☐ questioning or unsure
☐ same-gender-loving
☐ prefer to not answer

Self identify: _____

How comfortable are you being public with your sexual orientation?

☐ not at all ☐ a little ☐ somewhat ☐ moderately ☐ strongly

Current relationship structure:

☐ monogamous
☐ monogamish
☐ polyamorous
☐ open
☐ swinger
☐ prefer to not answer

Self identify: _____

International Students

Are you an international student? ☐ yes ☐ no

If yes, what country are you from? _____

Treatment History

Check all that apply:

Have you had counseling/ psychotherapy in the past?

☐ never ☐ prior to college ☐ after starting college ☐ during graduate or professional school

Have you taken psychiatric medicine in the past?

☐ never ☐ prior to college ☐ after starting college ☐ during graduate or professional school

If you have taken psychiatric medication, specify type, dosage, and frequency? _____

_____

_____

Have you ever been psychiatrically hospitalized?

☐ never ☐ prior to college ☐ after starting college ☐ during graduate or professional school

Current Treatment

Are you currently receiving counseling or therapy elsewhere? ☐ yes ☐ no

- If you are receiving therapy, please list the name and number of your current service provider:_____

Are you currently taking psychiatric medications? ☐ yes ☐ no

- If you are taking psychiatric medications, please specify type, dosage, and frequency:

  _____

  _____

Are you currently taking other medications (for non-psychiatric concerns)? ☐ yes ☐ no

- If you are taking other non-psychiatric medications, please specify type, dosage and frequency:

  _____

  _____

Are you currently using non-prescribed substances? ☐ yes ☐ no

Are you currently receiving care for any medical problems? ☐ yes ☐ no

- If you are receiving care, please describe:

  _____

  _____

Risk of Harm to Self or Others

Have you ever had thoughts of harming yourself? ☐ yes ☐ no

Have you had suicidal thoughts in the past year? ☐ yes ☐ no

Have you ever purposely injured yourself without a suicidal intent?
☐ currently doing so ☐ past, but stopped ☐ no

Have you ever made a suicide attempt? ☐ yes ☐ no

- If yes, when? ☐ prior to college ☐ after starting college ☐ both prior to & after starting college ☐ during graduate or professional school

Do you have current thoughts about harming someone? ☐ yes ☐ no

Have you ever intentionally physically harmed someone? ☐ yes ☐ no

- If yes, when? ☐ prior to college ☐ after starting college ☐ both prior to & after starting college ☐ during graduate or professional school

Substance Use

How often do you have a drink containing alcohol?
☐ never ☐ monthly or less ☐ 2 to 4 times a month ☐ 2 to 3 times a week ☐ 4 to 5 times a week ☐ 6 or more times a week

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 ☐ not applicable (I don't drink)

How often do you have 5 or more drinks on one occasion?
☐ never ☐ less than monthly ☐ monthly ☐ weekly ☐ daily or almost daily

Have you used any drug not prescribed for you by a doctor in past 30 days? ☐ yes ☐ no

What is your typical daily caffeine intake?
☐ none ☐ 1 to 2 cups/servings ☐ 3 to 5 cups/servings ☐ 5 or more cups/servings

Do you regularly use tobacco? ☐ yes ☐ no

Do you consider your alcohol or other substance use a problem? ☐ yes ☐ no ☐prefer to not answer

Medical History

Have you ever experienced any of the following?
☐ Head trauma
☐ Concussion
☐ Loss of consciousness
☐ Seizure
☐ Major surgery
☐ Major accident
☐ Medical hospitalization

- If not listed, please specify other significant medical conditions: _____

_____

Current Health

Rate your present physical health: ☐ poor ☐ unsatisfactory ☐ satisfactory ☐ good ☐ excellent

Do you have any significant medical concerns? _____

_____

How many hours per week do you exercise? ☐ none ☐ 1 to 5 hours ☐6 to 10 hours
☐ 11 to 15 hours ☐ 16+ hours

Miscellaneous

Have you ever experienced unwanted sexual contact? ☐ yes ☐ no

- If yes, when? _____

Have you ever experienced harassing/abusive behavior from another? ☐ yes ☐ no

- If yes, when? _____

Telemental Health Services Informed Consent Form

I hereby consent to engaging in telehealth with a psychological counselor at KUMC Counseling & Educational Support Services (CESS). I understand that "telehealth" includes the practice of education, goal setting, accountability, referral to resources, problem solving, skills training, and help with decision making. Telehealth psychotherapy may include psychological health care delivery, diagnosis, consultation, and psychotherapeutic treatment. Telehealth psychotherapy will occur primarily through interactive audio, video, telephone, email, instant messaging, and/or other data communications.

I understand that I have the following rights with respect to telehealth:
(1) I have the right to withhold or withdraw consent at any time. If consent is withheld or withdrawn, KUMC students and residents may meet with the psychological provider onsite at the KC campus or may request a referral to a local mental health provider
(2) I must complete an onsite, in-person screening by a CESS psychological counselor before participating in telehealth. The CESS counselor will inform you if a referral for telehealth services is appropriate. Receiving telehealth services may be contraindicated with:

- Recent suicide attempt(s), psychiatric hospitalization, or psychotic processing (last 3 years)
- Moderate to severe major depression or bipolar disorder symptoms
- Moderate to severe alcohol or drug abuse
- Severe eating disorders
- Repeated "acute" crises (e.g., occurring once a month or more frequently)

(3) For a KUMC student or resident to receive telehealth services, she/he must be physically located in a state where the telehealth provider is licensed (i.e., Kansas). Telehealth service may not be provided in international jurisdictions.
(4) The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my sessions is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; expressed threat to harm or kill self; and where I make my mental or emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent.
(5) I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the psychological counselor, that: the transmission of my personal information could be disrupted or distorted by technical failures; the transmission of my personal information could be interrupted by unauthorized persons; and/or the electronic storage of my personal information could be accessed by unauthorized persons. In addition, I understand that telehealth based services and care may not be as complete as face-to-face services. I also understand that if my psychological counselor believes I would be better served by another form of intervention (e.g. face-to-face services) I will be referred to a mental health professional who can provide such services in my area.
Finally, I understand that there are potential risks and benefits associated with any form of counseling, and that despite my efforts and the efforts of my psychological counselor, my condition may not improve, and in some cases may even get worse.
(6) I understand that I may benefit from telehealth psychological counseling, but that results cannot be guaranteed or assured.
(7) I understand that I have a right to access my personal information and copies of case records in accordance with Federal and Kansas law. I have read and understand the information provided above. I have discussed it with my psychological counselor, and all of my questions have been answered to my satisfaction.
(7) I understand that I have a right to access my personal information and copies of case records in accordance with Federal and Kansas law. I have read and understand the information provided above. I have discussed it with my psychological counselor, and all of my questions have been answered to my satisfaction.
(8) By electronically signing this document I agree that certain situations including emergencies and crises are inappropriate for audio/video/computer based psychological counseling services.

- If I am in crisis or in an emergency I should immediately call 911 or seek help from a hospital or crisis oriented health care facility in my immediate area. I understand that emergency situations include if I have thought about hurting or killing either another person or myself, if I have hallucinations, if I am in a life threatening or emergency

situation of any kind, having uncontrollable emotional reactions, or if I am dysfunctional due to abusing alcohol or drugs.

- I acknowledge I have been told that if I feel suicidal, I am to call 911 or the National Suicide Hotline Toll-Free Number at 1-800-784-2433 or other local suicide hotlines.

I acknowledge receipt of and agreement to the KUMC Counseling & Educational Support Services Consent for Telemental Health Services.

_____ _____

Signed ***Date***

_____

Print name

Please be sure you have answered all questions, then scroll to continue below. Thank you!

Student Health, Counseling and Educational Support Services Consent for Treatment

Student Health Services (SHS) and Counseling & Educational Support Services (CESS) provides health services, personal and educational counseling, psychological and learning assessment, and psychiatric services. SHS also assists students with health and immunization requirements.

Policy for Use of Services

For SHS, students enrolled in an on-campus course (Kansas City) who pay the "Health Services" fee are eligible for services. For CESS, students who have paid the "Educational Services" fee, residents, post-doctoral fellows and accompanying partners or family members (couples/family counseling only) are eligible for services. Students who haven't paid these fees but are in KU academic program or are a spouse or partner of an on-campus KUMC student may receive services by paying these fees by semester. There is no fee for a health and education appointment once the semester fee is paid. Fees may be assessed for specific procedures, tests, or no-showed appointments. CESS psychiatric appointments are provided at $25 per visit. CESS group appointments are provided at no cost. If you have questions about fees for these services, you should contact SHS or CESS.

Consent to Release of Records

Each time I utilize Student Health, Counseling or Psychiatric Services, a record is generated. This record contains medical information about you ("medical records"). I authorize SHS or CESS to furnish requested information or excerpts from my medical records according to the uses and disclosure outlined in the Notice of Privacy Practices. This includes release of my medical records to any insurance company, health plan or sponsoring agency who may be providing financial assistance for medical care (as well as any agents or review agencies necessary for processing any claim), including Medicare and Medicaid, for the purpose of obtaining payment; and to any physician, hospital, laboratory, radiological facility or other health care provider I am referred from or to if the release of medical records is necessary to support continuity of care. I authorize the release of my medical records for health care operations purposes of SHS and CESS. I understand that these medical records may include all information relative to my physical condition, past and present, including the diagnosis and history of sexually transmitted diseases including HIV/AIDS , psychiatric history and alcohol or drug abuse information. I authorize and consent to the release of information about vaccination status to schools, facilities and rotation sites. In addition, I authorize SHS to inform the appropriate people in the event of illness that would prevent participation in academic endeavors and clinical rotations. I consent and authorize the release of information required to comply with federal and state law. I agree that SHS or CESS, its agents and employees, are not liable if individuals or companies to whom they release medical or financial information disclose the information without my written consent. I authorize SHS and CESS to use and disclose my medical information for the purposes of marketing or promoting services and/or activities of SHS and CESS that may benefit me.

Client Rights & Responsibilities

1. Evaluation: You are encouraged to discuss your progress with your provider. If you feel that you are not making progress toward your goals, you should discuss this directly with the staff member. If necessary, you may terminate services with the staff member or ask him or her to refer you to another department provider or external agency.
2. Active Participation: For services to be effective, it is necessary for you to take an active role. We invite you to be authentic, discussing concerns openly, completing outside assignments when appropriate, listening, and providing feedback.
3. Keeping Appointments: We expect that you will notify us at least 24 hours in advance if you cannot or choose not to keep an appointment. If there are repeated no-shows or cancellations with less than 24 hours, your slot may be given to another individual. You may be assessed a fee for no-shows or late cancellations. We will always attempt to contact you if we need to change an appointment. Occasionally, an emergency will prevent us from doing so in a timely manner.
4. End or Begin Services with Another Agency for Counseling: If you decide to end services or begin receiving services from another agency, we request that you discuss your decision with your provider.

Professional Staff Member Rights

1. Refuse Services While Under the Influence of Alcohol or Drugs. At the staff's discretion, you may be refused services if you are currently under the influence of drugs or alcohol.
2. Terminate or Refer to Another Service Provider: When we believe that our services are not or will not be appropriate for you, we may, after discussing our reasons with you, decide to end services and refer you to another provider or agency in the community.

I acknowledge receipt of, and agreement to, the Student Health, Counseling and Educational Support Center's Consent for Treatment and I authorize release of my medical records as outlined in this Consent for Treatment and the Notice of Privacy Practices.

Print Name: _____

Signature: _____

Date: _____

NOTICE OF PRIVACY PRACTICES
Student Health, Counseling and Psychiatric Services
Effective Date: January 5, 2015

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

To serve you better, this Notice about our privacy practices and your privacy rights is provided to you. Please read the entire document for a full description of our practices and your rights. If you need more information or have any questions, you may call the Privacy Officer at (913) 588-0940.

Our responsibilities regarding your medical information.

Each time you utilize Student Health, Counseling or Psychiatric Services, a record is generated. This record contains medical information about you ("medical records"). This Notice applies to all of your medical records generated by the Counseling and Educational Support Center and the Student Health Center on the University of Kansas Medical Center campus. All of the providers at the Student Health Center and the Counselors and Psychiatrist at the Counseling and Educational Support Center will follow the terms of this Notice. This Notice does not apply to records created by Academic Accommodations, The Writing Center, and Educational Support Services**.**

We are required by law to protect the privacy of your medical information, provide you with this Notice, abide by the terms of the Notice currently in effect, and notify you if we are unable to agree to a requested restriction on use or disclosure of your medical information.

How We May Use and Share Your Medical Information

We may use and share your medical information as listed below. Not every possible use or disclosure will be listed. However, all of the ways we may use and share information falls into one of these areas.

For Treatment. When you first apply for services from Student Health, Counseling or Psychiatric Services we will ask you to consent to the release of your medical records for treatment purposes. This means we may use your medical information to give you medical care, and we may share your medical information with doctors, nurses, technicians, or other staff. For example, we may share your information with other people outside Student Health, Counseling and Psychiatric Services to coordinate care. This information may include medical records, prescriptions, and lab work.

For Payment. When you first apply for services from Student Health, Counseling or Psychiatric Services we will ask you to consent to the release of your medical records for payment purposes. This means we may use and share your medical information with your insurance plan or others who help pay for your care. For example, we may tell your health plan about a treatment you are going to receive. We do this to find out if your plan will pay for the treatment.

For Health Care Operations. When you first apply for services from Student Health, Counseling or Psychiatric Services we will ask you to consent to the release of your medical records for health care operations purposes. For example, we may use medical information to review our treatment and services and to measure the performance of our staff and how they care for you. This allows us to share medical information for teaching purposes or preparatory to research. If you are a student at the University of Kansas we may release limited information about you regarding receipt of certain tests, lab results, and vaccinations required for you to be enrolled at the University of Kansas or meet the requirements of a facility to which you rotate.

Business Associates. We may contract with outside businesses to provide some services for us. For example, we may use the services of collection agencies and software vendors. Under such contracts, we may share your medical information with them to do the job we have asked them to do. These contracts require businesses to protect the medical information we share with them and to provide you with access to your medical information and a list of any of your medical information that they disclose.

Appointment Reminders. We may contact you to remind you about your appointment for medical care.

People Involved In Your Care. Unless you ask us not to, we may share your medical information with a family member or friend who helps with your medical care. We may share your medical information with a group helping with disaster relief efforts. We do this so your family can be told about your location and condition. If you are not present or able to say agree or object to the sharing of your information, we may use our judgment to decide if sharing your information is in your best interest.

To Prevent A Serious Threat To Health Or Safety. We may use and share your medical information to prevent a serious threat to your health and safety and that of others. We will only share your medical information with persons who can help prevent the threat.

How We May Use and Share Your Medical Information Special Situations

In certain situations, Student Health, Counseling and Psychiatric Services may use or disclose medical information about you without your consent or authorization, for example, when there is an emergency or when there are substantial communication barriers to obtaining consent from you. Further, Student Health, Counseling and Psychiatric Services may use or disclose your medical information without your consent or authorization in the following circumstances:

As Required by Law. When you first apply for services from Student Health, Counseling and Psychiatric Services, we will ask you to consent to disclosures required by law. These uses and disclosures to the following types of entities: Food and Drug Administration; The Department of Health and Human Services or Education, Public health authorities or legal authorities charged with tracking, preventing or controlling diseases (e.g., communicable diseases, STDs, HIV), injuries or disabilities; workers compensation agents; proper military authorities, state or national security or intelligence authorities; and health oversight agencies.

Law Enforcement/Legal Proceedings. Student Health, Counseling and Psychiatric Services may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena or other legal process. If you are a student, we will make reasonable effort to notify you in advance of complying with the subpoena or court order so that you can take protective action unless we are legally required not to disclose the existence of the subpoena.

Research. Student Health Counseling and Psychiatric Services may disclose medical information to researchers when their research has been approved by an institutional review board.

Your Rights Regarding Medical Information About You

You have the following rights regarding medical information we maintain about you:

Right To Access and To Receive Copies. You have the right to look at and to receive copies of the medical information used to make decisions about your care, including information kept in an electronic health record, and/or to tell us where to send the information. Usually, this includes medical and billing records. It does not include some records such as psychotherapy notes.

To look at and to receive copies of medical information used to make decisions about you, you must submit your request in writing to Student Health and Fitness Information Manager for SHS records or Senior Director of Counseling and Educational Support for counseling or psychiatric records. We may charge a fee for the costs of processing your request. In some limited cases, we may say no to your request, such as a request for psychotherapy notes. You may ask that such a decision be reviewed. To ask for a review, contact the Privacy Officer in writing at 3901 Rainbow Blvd. Mailstop 1032, Kansas City, Kansas 66160.

Right To Amend. You have the right to ask for an amendment of your medical information that you believe is inaccurate, misleading, or in violation of your rights. You must make your request in writing on the approved form and submit it to the Privacy Officer at 3901 Rainbow Blvd. Mailstop 1032, Kansas City, Kansas 66160. You must give a reason that supports your request. We will give the form to request amendment of your medical records to you upon request.
We may say no to your request for an amendment to your record if your request is not in writing or does not include a reason to support the request. We also may say no to your request if you ask us to amend information that:

- we did not create, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the records used to make decisions about you;
- is not part of the information which you are permitted to inspect and to receive a copy; or
- is accurate and complete

Right To Accounting of Disclosures. You have the right to get a list of the disclosures we made of your medical information including medical information we maintain in an electronic health record. This list may not include all disclosures that we made. For example, this list will not include disclosures that we made for treatment, payment or health care operations purposes. To ask for this list you must submit your request in writing on the approved form. We will give you the form upon request.
Right To Request Restrictions. You have the right to ask for a restriction or limitation on the medical information we use or share for treatment, payment or health care operations. In addition, you have the right to request that we restrict disclosure of your medical information if the disclosure is to a health plan for the purpose of carrying out payment or health care operations (and is not for the purpose of carrying out treatment) and the medical information pertains solely to a health care item or

service for which you have paid out-of-pocket in full. You also have the right to ask for a limit on the medical information we share with someone who is involved in your care or in the payment for your care. Such a person may be a family member or friend. We do not have to agree to your request. If we do agree, we will fulfill your request unless the information is needed to provide you with emergency treatment.

To ask for restrictions, you must make your request in writing on a form that we will give you upon request. You must tell us:

- what information you want to limit,
- how you want us to limit the information, and
- to whom you want the limits to apply.

Right To Request Confidential Communications. You have the right to ask us to communicate with you about medical matters in a certain way or at certain places. You must make your request in writing on a form that we will give you upon request. We will fulfill all reasonable requests.

Right To a Paper Copy of This Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to get this Notice electronically, you still have a right to receive a paper copy.

Revisions To This Notice

We may update this Notice to show any changes in our privacy practices. We reserve the right to make the updated Notice effective for medical information we already have about you. It also will be effective for any information we receive in the future. We will post a copy of the current Notice in the places where you receive services. The effective date of this Notice is on the first page.

Complaints

If you think your privacy rights have been violated, you may file a complaint with Student Health, Counseling and Psychiatric Services or with the Secretary of the Department of Health and Human Services (medical records) or the United States Department of Education (education records). If you want to file a complaint with Student Health, Counseling and Psychiatric Service, contact the Privacy Officer at (913) 588-0940. You will not be retaliated against for filing a complaint.

Notification of Breach

We will keep your medical information private and secure as required by law. If any of your medical information which is acquired, accessed, used or disclosed in a manner that is not permitted by law we will notify you within 60 days following the discovery of a breach.

Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this Notice or by other laws that apply to us will be made only with your written permission. The following is a description of some situations, but not all, where our use and disclosure of your medical information will require your written permission:

Psychotherapy Notes. Most uses and disclosures of your psychotherapy notes will require your written permission. Generally speaking, psychotherapy notes are notes that are made by a mental health professional documenting or analyzing the contents of his or her conversations with you during a counseling session and that are kept separate from the rest of your medical record.

Marketing Purposes. Subject to limited exceptions, uses and disclosures of your medical information for marketing purposes will require your written permission.

I acknowledge receipt of, and agreement to, the Student Health, Counseling and Educational Support Center's Notice of Privacy Practices.

Print Name: _____

Signature: _____

Date: _____