

The Art Institutes International Minnesota

Student Counseling Services

GENERAL INFORMATION

Name _____

Date of Birth: _____

Phone/email _____

Relationship Status / Primary Support System:

Program / Major _____ What year? _____

Employer _____ Hours/week _____

How did you hear about AiM counseling services? _____

What brought you here to seek counseling support? _____

MEDICAL INFORMATION

Physician _____

Phone #: _____

Do you have any current concerns about your physical health? Please specify:

Have you had any significant medical problems in the past? Please specify:

Please list **any** medicines you are currently taking, or have taken during the past year.

Describe your alcohol or other chemical/substance use.

Have you ever had mental health treatment? Y / N / Inpatient / Outpatient (circle)

How long ago?

CLIENT BILL OF RIGHTS

As a consumer of Ai Minnesota counseling services you have the right to:

- a) expect that the counselor or student has met the minimal requirements of training and experience required by law;
- b) examine public records maintained by the certification board of the practitioner;
- c) obtain a copy of the Rules of Conduct from that certification board
- d) report complaints to that board or to the Dean of Student Affairs
- e) receive referrals to other qualified providers
- f) privacy as defined by rule and law; and
- g) Be free from being the object of discrimination on the basis of race, religion, gender or other unlawful category while receiving psychological services.

Additionally, you have the right to:

- a) quality service, considerate and respectful care;
- b) privacy/confidentiality except where federal and state law prohibit that:
 - a. Child Abuse and Vulnerable Adult reporting laws;
 - b. Emergency threatening of harm to self or other
 - c. Court order
 - d. Abuse or misconduct by other health care professionals.
- c) understand the extent of your problem, recommended treatment, treatment cost and expected outcome;
- d) refuse treatment;
- e) Information regarding your care and access to your file with guidance from the clinician.

I understand the above statements regarding Clients Rights.

NAME _____

DATE _____

THE ART INSTITUTES INTERNATIONAL MINNESOTA

Student Counseling Services

Informed Consent

Mission Statement: The role of the Student Counseling Services is to assist students to define and accomplish personal, academic, and career goals through the provision of high quality counseling services, programming, assessment and referrals.

1. **Eligibility for Services:** Counseling services are free and available to all currently enrolled students, or students who were enrolled the previous quarter and will be enrolling for the subsequent quarter.
2. **Services:** Counseling is provided by Student Counseling Services staff (a master's level licensed practitioner and supervised master's level students.) The Student Counseling Services provides short-term counseling. If it is determined that you need more intensive or long-term therapy, or that you require resources not provided here, a referral to an appropriate off-campus provider will be made.
3. **Confidentiality:** The Student Counseling Services is staffed by a professional licensed psychological practitioner. Within ethical and legal guidelines, information shared with a clinician cannot be disclosed to anyone without the student's written consent. There are **exceptions** to this:
 - **if you present a clear and imminent danger to yourself or someone else**
 - **in the case of abuse or neglect of a child under the age of 18, or abuse of a vulnerable adult (an adult who is unable to provide self-protection)**
 - **in the event of a court order for information**
 - **in the event that you are pregnant and using controlled substances**
 - **Minnesota law states that parents and /or spouse have the right to access their deceased child's or spouse's health care records**
 - **Minnesota law requires health care providers (including psychological practitioners) to report possible misconduct by another licensed health care professional to the appropriate Board, if that person is identified by name.**
 - **Under Minnesota law, health care professionals may notify the Minnesota Department of Health of individuals who are HIV positive (or who have AIDS) and having unprotected sex.**
 - **The AIM Student counseling Service encourages affected individuals to contact the Minnesota Department of Health at 651-201-5414 to obtain information about available resources, including the Partner Notification Program.**

4. **Counseling Records:** Your counseling records are protected by all existing laws governing medical records. Your counseling record is not part of your academic or administrative record. Records are maintained for 7 years, and then destroyed. Upon written request, a copy of your records or a written summary can be provided to another health care professional.
 5. **Services not provided:** Services that require court testimony, or reports/letters to be filed with any District Attorney's office or any State Department of probation or parole, or involve litigation.
 6. **Consultation:** While working with you, the counselor may confer with a therapy consultant, clinical or administrative supervisor. Consultations are performed in a confidential and professional manner, with the goal of providing you with the best possible care.
 7. **Changing /missed appointments:** If you need to cancel an appointment, or if you wish to re-schedule your appointment, please call the Student Counseling Services at 612-656-6866.
- *Repeated cancellations or missed appointments may result in interruption or loss of counseling services.**

If you have any questions or are unclear about these policies, please discuss them with your counselor.

Consent

I have been provided with a written description of services, confidentiality, and records procedures for the Student Counseling Services at AIM. I have been provided with the opportunity to read and discuss the information contained in this document. Any questions I had have been answered to my satisfaction, and I fully understand and agree to these policies. I also understand that I may terminate counseling at any time.

Student	Date
Counselor	Date

SOCIAL HISTORY

FAMILY BACKGROUND

Please describe the family you were raised in.

In your family life as a child, list any critical events and your age when they occurred (e.g. deaths, divorce, hospitalization, loss of job, a difficult move).

List the names of children in your family of origin in order of birth including yourself (your brothers and sisters).

Do you have a significant other?

For how long?

Indicate your level of satisfaction with the relationship: (1 = Very dissatisfied.....5 = Very satisfied)

1-----2-----3-----4-----5

Do you have any children?

If applicable, please list the ages and genders of your children:

Do any of your children have special needs?

The Art Institutes International Minnesota Student Counseling Services

SELF ASSESSMENT OF FUNCTIONING

Date: _____ Name: _____

People who seek counseling may experience difficulty functioning in various areas of daily life. On the scale below, please indicate the level of difficulty you have functioning in the following areas:

In answering these questions, please refer to this scale:

1 - No Difficulty 2 - Mild Difficulty 3 - Moderate Difficulty 4 - Severe Difficulty
5 - Incapacitating Difficulty

A. School and/or Job

1-----2-----3-----4-----5

Briefly describe the difficulties you have functioning at work:

B. Relationship with Peers and/or Co-Workers

1-----2-----3-----4-----5

Briefly describe the difficulties you have functioning with co-workers:

C. Household tasks

1-----2-----3-----4-----5

Briefly describe the difficulties you have carrying out household tasks:

D. Relationship with significant other / spouse

1-----2-----3-----4-----5

Briefly describe the difficulties you have functioning as a spouse or significant other:

E. Relationships with family members (parents / children)

1-----2-----3-----4-----5

Briefly describe:

F. Relationship with friends

1-----2-----3-----4-----5

Briefly describe the difficulties you have functioning as a friend:

G. Self-care (diet, exercise, sleep, time to relax, etc.)

1-----2-----3-----4-----5

Briefly describe the difficulties you have taking care of yourself:

H. Recreation

1-----2-----3-----4-----5

Briefly describe your difficulties in recreation/leisure areas:

2. On the scale below, please estimate the overall level of difficulty you have functioning in life:

1-----2-----3-----4-----5

Listed below are a number of common symptoms. Please check all that apply to you.

PHYSICAL EXPERIENCES

- | | |
|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Shallow, rapid or tight breathing |
| <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Back pain |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Muscle tension |
| <input type="checkbox"/> Fatigue/exhaustion | <input type="checkbox"/> Muscle twitches/tremors |
| <input type="checkbox"/> Seizures/convulsions | <input type="checkbox"/> Sexual difficulties |
| <input type="checkbox"/> Blackouts | <input type="checkbox"/> Bowel disturbances |
| <input type="checkbox"/> Visual disturbances | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Sudden weight changes |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Marked change in sex drive |
| <input type="checkbox"/> Oversleeping | <input type="checkbox"/> Stomach trouble |
| <input type="checkbox"/> Neck/shoulder pain | <input type="checkbox"/> Flushes |
| <input type="checkbox"/> Rapid heart rate | <input type="checkbox"/> Burning or itchy skin |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Excessive sweating |

FEELINGS

- | | |
|---|--|
| <input type="checkbox"/> Unusually happy/euphoric | <input type="checkbox"/> Feeling helpless |
| <input type="checkbox"/> Agitation: feeling jumpy | <input type="checkbox"/> Feeling discouraged/down in the dumps |
| <input type="checkbox"/> Sudden changes in mood | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Feeling bored/disinterested in most activities | <input type="checkbox"/> Periods of panic |
| <input type="checkbox"/> Overreacting to things | <input type="checkbox"/> Fear of losing control or going "crazy" |
| <input type="checkbox"/> Not feeling much of anything | <input type="checkbox"/> Anxious/apprehensive much of the time |
| <input type="checkbox"/> Feeling guilty/ashamed | <input type="checkbox"/> Frustrated/angry much of the time |
| <input type="checkbox"/> Feeling lonely/empty | <input type="checkbox"/> Suspicious feelings toward others |
| <input type="checkbox"/> Feeling worthless | <input type="checkbox"/> Feeling hungry for approval from others |
| <input type="checkbox"/> Feeling hopeless | |

THOUGHTS

- | | |
|---|---|
| <input type="checkbox"/> Tend to deny problems that others see | <input type="checkbox"/> Difficulty concentrating |
| <input type="checkbox"/> Difficulty listening to or understanding new ideas | <input type="checkbox"/> Inability to remember periods of your life |
| <input type="checkbox"/> Jump from thought to thought | <input type="checkbox"/> Believing that your thoughts cause things to |
| <input type="checkbox"/> Thoughts going too fast/too slow | <input type="checkbox"/> Constantly comparing yourself to others |
| <input type="checkbox"/> Mind goes blank | <input type="checkbox"/> Difficulty making decisions |
| <input type="checkbox"/> Overly self-conscious | <input type="checkbox"/> Having unwanted thoughts again and again |
| <input type="checkbox"/> Tend to focus on the past | <input type="checkbox"/> Painful or unwanted memories |
| <input type="checkbox"/> Tend to see people and events in a negative | <input type="checkbox"/> Confusion |
| <input type="checkbox"/> Thoughts about hurting yourself | <input type="checkbox"/> Worrying about your health |
| <input type="checkbox"/> Hearing things with no apparent cause | <input type="checkbox"/> Destructive fantasies or images |
| <input type="checkbox"/> Seeing things with no apparent cause | <input type="checkbox"/> Believing that people are generally vindictive |
| <input type="checkbox"/> Self-critical thoughts | |

BEHAVIORS

- Marked change in activity level
- Doing dangerous activities
- Poor performance at work
- Dishonest behavior: lying/stealing
- Use drugs/alcohol to feel better
- Overeating/undereating
- Often in a hurry
- Marked change in pattern of eating
- Focusing too much on some parts of life and neglecting others
- Angry outbursts, aggressive or destructive behavior that need to be done
- Nervous behaviors (can't sit still, nailbiting, etc.)
- Self-harming behavior
- Impulsive behavior
- Behavior inconsistent with your personal values
- Repeating certain acts again and again
- Trying to do things perfectly
- Staying up too late at night
- Not showing up for work/arriving late
- Difficulty getting out of bed in the morning
- Procrastination: avoiding or putting off things

RELATIONSHIPS

- Difficulty relating to others at work: e.g., a supervisor, supervisee or co-worker
- Difficulty relating to family members/relatives
- Difficulty relating to spouse/significant other
- Relying on others to make your decisions or take care of you
- Withdrawing from others/isolating yourself
- Engaging in sexual behavior you don't like
- Letting others take advantage of you
- Difficulty expressing feelings
- Try too hard to please others
- Difficulty building friendships/relating to friends
- Difficulty with your sexual life
- Difficulty listening to others
- Nag others or frequently criticize others
- Act phoney: not being yourself
- Verbally attack or blame others
- Physically fight with others

Please note any other information you feel it is important for your counselor to know, if any.