Counseling and Psychological Services
General Information Form

Welcome to CAPS! We’re happy you have decided to make an appointment with our office, and we’re looking forward to discussing your concerns with you and providing assistance as you negotiate your life’s challenges. Your signature on this form indicates you have read and understand the following policies and procedures.

- CAPS operates on a clinic model, which means you and your therapist will schedule your appointments on a week-to-week basis.

- CAPS utilizes a short-term psychotherapy model, which allows us to welcome new students to our office throughout the year. If you think you need more intensive long-term therapy, or if you need the consistency and structure of the same time/day every week, then you may prefer to see a community provider. CAPS maintains a list of community resources, and although we do not specifically endorse any particular provider we are happy to help students choose one who is likely to be a good fit.

- All intake paperwork is voluntary and confidential. However, if you wish to receive psychotherapy services from CAPS you must sign the “Informed Consent for Counseling” Form. The “Notice of Privacy Practice” form informs you of your privacy rights. The survey form asks you various questions about your present life, your history, and your current concerns.

- If at some point you decide to pursue medication management through CAPS, your therapist will explain all relevant policies and procedures to you. Please be aware that ALL students who receive prescriptions from CAPS are required to see a therapist as well.

- If you ever experience an emergency situation after regular appointment hours or on weekends, one of our therapists is always on call to assist. You can reach the on-call therapist by calling 860.685.2910.

- Please be aware we charge a $10 fee to your student account if you fail to attend an appointment or if you cancel with less than 24 hours’ notice.

If you have any questions or comments, please let your therapist know.

________________________________________  ______________________________________
Signature                                           Witness

________________________________________  ______________________________________
Date                                               Date
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I have read “Counseling and Psychological Services General Information Form” and understand its provisions regarding individual psychotherapy, confidentiality, medication management, emergency procedures, and fees.

I understand all possible efforts are made by CAPS staff and trainees to maintain confidentiality in individual and group psychotherapy as well as record-keeping. I further understand there are circumstances in which I do not have the privilege of confidentiality. These include the following: my therapist judges me to present an imminent threat of harm to myself or others, I disclose information about child, dependent adult, or elderly person abuse and/or neglect, I am a minor and I report being physically and/or sexually abused, or a judge orders the disclosure of my CAPS chart.

I understand that counseling is an active and cooperative effort of both student and therapist. I further understand that neither CAPS nor its staff makes any guarantee of the results or outcomes of my counseling. CAPS guarantees that all staff members will behave according to all applicable state laws and ethical standards of their professions, and will use only interventions that are approved practice within their professions.

Signature

Date
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Counseling and Psychological Services
Notice of Privacy Practices

This notice describes how your medical information may be used and disclosed and how you can access this information. Please review it carefully.

The Office Counseling and Psychological Services (CAPS) must maintain the privacy of your personal health information and give you this notice that describes our legal duties and privacy practices concerning your personal health information. In general, when we release your health information, we must release only the information we need to achieve the purpose of use or disclosure. However, your own CAPS information will be available for release to you, to a provider regarding your treatment, or due to legal requirement. We must follow the privacy practices described in this notice.

However, we reserve the right to change the privacy practices described in this notice, in accordance with the law. Changes to our privacy practices would apply to all health information we maintain. If we change our privacy practices, you may obtain a revised copy by calling the office and requesting that a revised copy be sent to you.

I. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information Based Upon Your Written Consent

Upon entry to the University, you have signed a consent form to authorize CAPS to provide mental health services if you request it. Once you have signed our consent form, we can use your mental health information for the following purposes: Please note that if you refuse to provide consent to us, we may refuse to treat you.

A. Treatment: We will use and disclose your protected CAPS information to provide, coordinate, or manage your mental health care and any related services. This includes coordination or management of your mental health care with a person or entity with or which has already obtained your permission to have access to your protected mental health information. For example, we would disclose protected mental health information, with your permission, to another mental health care provider to ensure that they have the necessary information to diagnose and treat you. In addition, we may disclose your protected mental health information from time to time to another mental health care provider, who, at the request of your provider, becomes involved in your mental health care by providing assistance with your diagnosis or treatment to your mental health care provider.

B. Payment: Your visits to CAPS are covered by the yearly Student Health Fee, and CAPS does not charge for these visits. Also, if you are referred for services outside of CAPS for a problem diagnosed at CAPS we may release to your insurance company, with your permission, relevant protected mental health information to assist them in determining your eligibility for coverage.
and benefits outside of CAPS and in reviewing services provided to you outside of CAPS to determine necessity.

C  **CAPS Operations**: We may use or disclose, as needed, your protected mental health information in the administrative activities of CAPS. These activities would be: quality issues review activities; employee review activities; and possibly in the course of standard office procedures, we may call you by name in the waiting room.

**Uses and Disclosures of Protected Health Information Based Upon Your Written Authorization**

Other uses and disclosures of your protected mental health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing, except to the extent that the CAPS has already sent out the requested information.

We may use and disclose your protected mental health information in the following instances. You have the right to agree or object to the use and disclosure of all or part of your protected mental health information. If you are not able to agree or object to the use or disclosure of protected mental health information, then your therapist, in his/her professional judgment, will determine whether the disclosure is in your best interest. In this case, only the mental health information that is relevant to your current health problem will be discussed.

A. **Others Involved in Your Health Care**: Unless you object, we may disclose to a member of your family or a close friend or any other person you identify, your protected mental health information that directly relates to their involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose the information as necessary if we determine that it is in your best interest, based on our professional judgment, to use and disclose your protected mental health information to notify or assist in notifying a family member, personal friend, or any other person that is responsible for your care, of your location, general condition or death. Finally, we may use or disclose your protected mental health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family and other individuals involved in your health care.

B. **Emergencies**: We may use or disclose your protected mental health information in an emergency treatment. If this happens, your mental health care provider shall try to obtain your consent as soon as reasonably practicable after the treatment.

C. **Communication Barriers**: We may use or disclose your protected mental health information if your therapist in CAPS attempts to obtain consent from you but is unable to do so due to substantial language barriers and the practitioner determines, using professional judgment, that you intend to consent to treatment under the circumstances.
Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent or Opportunity to Object.

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

A. **Required By Law:** We may use or disclose your protected mental health information to the extent that the use is required by law. The use or disclosure will be made in compliance with the law, and will be limited to the requirements of the law. For example, we may have to report abuse, neglect, domestic violence, or certain physical injuries, correspond to a court order. You will be notified, as required by law, of any such uses or disclosures.

B. **Public Health:** We may disclose your protected mental health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected mental health information as directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

C. **Communicable Diseases:** We may disclose your protected mental health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading that disease or condition.

D. **Health Oversight:** We may disclose your protected mental health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information may include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

E. **Food and Drug Administration:** We may disclose your protected mental health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls, to make repairs or replacements, or to conduct post marketing surveillance as required.

F. **Legal Proceedings:** We may disclose protected mental health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful proceeding.

G. **Law Enforcement:** We may also disclose protected mental health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurred on the premises of the practice, and (6) medical emergency (not on the practice premises) and it is likely that a crime has occurred.
H. **Coroners, Funeral Directors and Organ Donation:** We may disclose protected mental health information to a coroner or medical examiner for identification purposes, determining the cause of death, or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected mental health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected mental health information may be used and disclosed for cadaver organ, eye and tissue donations.

I. **Research:** We may disclose your protected mental health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal, and established protocols to ensure the privacy of your protected mental health information. For example, such research might help determine whether a certain treatment is effective in curing an illness.

J. **Criminal Activity:** Consistent with applicable federal and state laws, we may disclose your protected mental health information if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public. We may also disclose protected mental health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

K. **Military Activity and National Security:** When the appropriate conditions apply, we may use or disclose the protected mental health information of individuals who are Armed Forces personnel (1) for the activities deemed necessary by military command authorities; (2) for the purpose of a determination by the Department of Veteran’s Administration eligibility for benefits, or (3) to a foreign military authority if you are a member of that foreign military service. We may also disclose your protected mental health information to authorized federal officials for conducting national security and intelligence activities, including the provision of protective services to the President or others legally authorized.

L. **Worker’s Compensation:** We may use or disclose your protected mental health information, as authorized, to comply with worker’s compensation laws and other similar legally established programs.

M. **Inmates:** We may use or disclose your protected mental health information if you are an inmate of a correctional facility and your therapist created or received your protected mental health information in the course of providing care to you.

N. **Required Uses and Disclosures:** Under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et.seq.
II. Your Rights

Following is a statement of your rights with respect to your protected mental health information and a brief description of how you may exercise these rights:

A. **You have the right to inspect and obtain a copy of your protected mental health information.** This means you may obtain a copy of protected mental health information about you that is contained in a designated file for as long as we maintain the protected mental health information. A “designated file” contains medical records and other records that your therapist and the practice uses for making decisions about you.

Under federal law, however, **you may not inspect or copy the following records:** Psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding, and protected mental health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have the right to have this decision reviewed. Please contact our Privacy Contact, listed at the end of this notice, if you have questions about access to your medical record.

B. **You have the right to request a restriction of your protected mental health information.** This means you may ask us not to use or disclose any part of your protected mental health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected mental health information not be disclosed to family members or friends who may be involved in your care, or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want this restriction of access to apply. Your provider/therapist is not required to agree to a restriction that you may request. If the provider/therapist believes it is in your best interest to permit use and disclosure of your protected mental health information, your protected mental health information will not be restricted. If your provider/therapist does agree to the requested restriction, we may not use or disclose your protected mental health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your provider/therapist. You may request a restriction by discussing it with your provider/therapist, and then requesting the specific restriction in writing.

C. **You have the right to request to receive confidential communications from us by alternative means or at an alternative location.** We will accommodate reasonable requests. We may also qualify this accommodation or specification for an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Contact, listed below.
D. You may have the right to have your provider/therapist amend your protected mental health information. This means you may request an amendment of protected mental health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Contact listed below if you have any questions about amending your CAPS file.

E. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected mental health information. This right applies to disclosures for the purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made, to family members or friends involved in your care, or for notification purposes. The right to receive this information is subject to certain exceptions, restrictions and limitations.

F. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

III. Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe we have violated your privacy rights. You may file a complaint with us by notifying our Privacy Contact of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Contact, Chariklia Flanagan at 860-685-3143, or CAPS, 327 High Street, Middletown, CT 06459, for further information about the complaint process or any other questions you have regarding this notice.

This notice was published and becomes effective on April 14, 2003.
Wesleyan University
Counseling and Psychological Services
Receipt of Privacy Notice

I, ________________________________, have received a copy of the Wesleyan University Counseling and Psychological Services Notice of Privacy Practices.

Signature __________________________
Class Year _________________________
Date ______________________________

Witness ____________________________
Date ______________________________
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*Please Note: All information provided is VOLUNTARY and CONFIDENTIAL. CAPS utilizes student data to evaluate and improve the services we provide the Wesleyan community.*

Name ___________________________________________ Date ____________________

Date of Birth _____ Age _____ Gender ________ Health Insurance: ________

Wesleyan ID _________________ Social Security Number __________________

Local Residence ___________ Roommate/Housemate Name(s) ________________

Cell Phone _________________ Email Address _____________________________

Home Address __________________________________ Home Phone ___________

High School ___________________ High School GPA________________________

Type: Private _____ Public _____ Boarding _____ Day ______

Have you experienced any LEARNING PROBLEMS in the past? ____________________

If yes, please explain ___________________________________________________

Current Class Year ______________ Current GPA (estimate if uncertain) __________

Major __________________________ Career Plans _____________________________

Student Employee? (if yes, where?) ______________________________________

Reflection Staff? (if yes, where?) _________________________________________

Any Previous Colleges Attended __________________________________________

Race __________________________ Ethnicity ________________________________

Sexual Orientation _______________ Spiritual Affiliation ___________________

Other relevant aspects of cultural background not covered above? ________________

______________________________________________________________
**Additional Affiliations (please complete as many as apply)**

Transfer Student (please specify date and previous college) __________________________

Returning Student (please explain) _______________________________________________

International Student (please indicate home country) ______________________________

Student Athlete (include sport) __________________________________________________

1st Generation American Student (please include parents’ home country) ____________

1st Generation in College Student ________________________________________________

Student with Disabilities (please explain) _________________________________________

Veteran (please specify branch and time of service) _________________________________

Nontraditional Student (please explain) ____________________________________________

**Family Information**

**Parent 1:**
Name __________________________ Age _______ Highest degree ______________________
College (s) ______________________ Occupation _________________________________
Divorced (include year) ____________ Remarried (include year) ________________
Deceased (include year) ____________

**Parent 2:**
Name __________________________ Age _______ Highest Degree ______________________
College(s) ________________________ Occupation _________________________________
Divorced (include year) ____________ Remarried (include year) ________________
Deceased (include year) ____________

**Stepparent 1:**
Name __________________________ Age _______ Highest Degree ______________________
College(s) ________________________ Occupation _________________________________
Divorced (include year) ____________ Remarried (include year) ________________
Deceased (include year) ____________

**Stepparent 2:**
Name __________________________ Age _______ Highest Degree ______________________
College(s) ________________________ Occupation _________________________________
Divorced (include year) ____________ Remarried (include year) ________________
Deceased (include year) ____________
siblings (include step and half siblings and indicate where appropriate):

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were you raised by your birthparents? (if no, please describe; e.g. adoption, blended family, extended family, etc.)

family members with whom you live when not at school

mental health history

what is your main reason for seeking therapy now?

are you currently receiving psychotherapy or psychiatric services? (if yes, please describe)

are you currently taking any medication (including OTC, herbal supplements, vitamins)? Please list medication, dosage, provider, reason taken.

have you participated in psychotherapy or psychiatric services in the past? (if yes, please explain)

have you ever been hospitalized for psychiatric reasons? (if yes, please describe)

are you currently thinking about harming yourself?

have you ever intentionally injured yourself without suicidal intent (e.g. cutting)?
Have you ever made a suicide attempt? (if yes, please describe and provide date) __________

Have any of your family or friends died by suicide? (if yes, who and when) __________

Do you currently have thoughts of harming another person? (if yes, please describe) __________

Have you ever seriously considered harming another person? (if yes, please describe) __________

Have you recently experienced a traumatic or extremely upsetting event? (Explain) __________

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**Mental Health Concerns**

**Over the last 2 weeks, how often have you been bothered by any of the following problems?**

0 = Not at all  1 = Several days  2 = More than half the days  3 = Nearly every day

1. Little interest or pleasure in doing things
2. Feeling down, depressed, or hopeless
3. Trouble falling or staying asleep, or sleeping too much
4. Feeling tired or having little energy
5. Poor appetite or overeating
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down
7. Trouble concentrating on things, such as reading the newspaper or watching television
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual
9. Thoughts that you would be better off dead or of hurting yourself in some way

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

[ ] Not difficult at all    [ ] Somewhat difficult    [ ] Very difficult    [ ] Extremely difficult

10. Feeling nervous, anxious or on edge
11. Not being able to stop or control worrying
12. Worrying too much about different things
13. Trouble relaxing
14. Being so restless that it is hard to sit still
15. Becoming easily annoyed or irritable
16. Feeling afraid as if something awful might happen

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

[ ] Not difficult at all  [ ] Somewhat difficult  [ ] Very difficult  [ ] Extremely difficult

In your life, have you ever had any experience that was so frightening, horrible or upsetting that in the past month, you:

17. Have had nightmares about it or thought about it when you did not want to?

Yes  No

18. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?

Yes  No

19. Were constantly on guard, watchful or easily startled?

Yes  No

20. Felt numb or detached from others, activities, or your surroundings?

Yes  No

Notes: ________________________________

______________________________

SUBSTANCE USE

Do you regularly use alcohol? (if yes, please describe)______________________________

In a typical month, how often do you have 4 or more alcoholic drinks in a 24-hour period?

[ ] never  [ ] rarely  [ ] monthly  [ ] weekly  [ ] daily or almost daily

Do you think your alcohol use is a problem?_____________________________________

Have you used any substance in the past 30 days that was not prescribed by a doctor (e.g., marijuana, meth, MDMA, cocaine, Xanax or other benzodiazepines, Adderall or other stimulants, LSD or other hallucinogens, heroin or other narcotics)? (if yes, please indicate substances)__________________________

How often do you engage in recreational substance use?

[ ] never  [ ] rarely  [ ] monthly  [ ] weekly  [ ] daily or almost daily

Have you ever received treatment for alcohol and/or substance abuse or addiction? (if yes, please include when, where and for what substance(s))__________________________

______________________________
Wellness

Do you have current health/medical concerns (including allergies)?__________________________
________________________________________________________________________________

Have you experienced physical/medical issues in the past (include accidents, injuries, surgeries, loss of consciousness)? If yes, please describe and provide dates_____________________
________________________________________________________________________________

Are you experiencing any problems with sleep?__________________________________________
________________________________________________________________________________

Do you have current or past concerns with food, eating, exercise, weight, or body image? (if yes, please describe)____________________________
________________________________________________________________________________

Are you sexually active at present?____________________________________________________
________________________________________________________________________________

If you are sexually active, what contraceptives and/or safe sex practices do you utilize?____
________________________________________________________________________________

Do you have any problems or worries about sexual functioning? (please describe)________
________________________________________________________________________________

(If Relevant) Do your menstrual periods significantly affect your mood? (Explain)__________
________________________________________________________________________________

Are sexual orientation/gender identity/coming out concerns part of the reason for your visit to CAPS? __________________________________________
________________________________________________________________________________

Is there anything else you would like us to know about you?____________________________
________________________________________________________________________________