CONCORDIA UNIVERSITY IRVINE
COUNSELING AND PSYCHOLOGICAL SERVICES (CAPS)

Personal History Intake Form

The information on this form will not be reviewed until the first session with the therapist.

NAME**:** _____
First Middle Last

Please remember that any information provided, in written or oral form, is completely confidential and subject to the limitations discussed on the Consent for Treatment form. Please be as truthful as possible as you respond to the following questions.

Date of Birth**:** ____/____/____ Place of Birth: _____

Age: ____ Gender**:** ____

Religion: Lutheran ____ Baptist ____ Presbyterian ____
Catholic ____ Non-denominational ____
Other (please specify) _____ None ____

Ethnic Background**:**
African American ____ Asian American ____ Caucasian ____
Chicano/Latino ____ Middle Eastern ____ Native American ____
Other (please specify) _____

Status**:** Full time ____ Part-time ____ (Must be enrolled in at least 6 units in a semester period)

Undergraduate ____ Graduate ____

Residence**:** (Check all that apply)

On campus university housing ____ Live with parents/relatives ____
Live with roommates ___ Live alone ____
Off-campus housing ____

Contact Information (Read the acknowledgement under Consent for Treatment.)

Current address:_____City/ST _____

Or ☐ 1530 Concordia West, Irvine, CA 92612 DORM: _____

Permanent address (if different):_____City/ST _____

Telephone number to contact you at**:** (_____)_____

Email address: _____@eagles.cui.edu

Person to notify in an emergency:

Name:_____ Relationship: _____

Telephone: (_____)_____

Education:

Student Status: 1st yr. ____ 2nd yr. ____ 3rd yr. ____ 4th yr. ____ 5th yr. ____ Other ____

Academic Major: _____ GPA:_____ Number of Units:_____

Other universities/colleges attended:_____

Extra-Curricular Activity Participation: Sport Team/s:_____

Circle: (Choir) (Forensic) (Music) (Student Leadership) (Theater) Other: _____

Have you been diagnosed with a learning disability? _____

Are you currently working? Yes ____ No ____ Number of hours: _____ Where: _____

Medical/Mental Health History:

Primary Care Physician: _____ Physician Phone #:_____

Are you currently under a physician's care? Yes ____ No ____

Are you currently taking any medication? Yes ____ No ____

If yes list: Reason_____Medication/Dosage_____Prescribed by_____
Reason_____Medication/Dosage_____Prescribed by_____
Reason_____Medication/Dosage_____Prescribed by_____

List any current medical or mental health diagnosis:_____

_____

Have you ever been hospitalized for medical concerns? Yes ____ No ____

Have you ever been hospitalized for mental health concerns? Yes ____ No ____

How would you describe your overall physical health? Very Good ____ Good ____ Not So Good ____

Have you had previous psychotherapy experiences? Yes ____ No ____

When _____ Where _____
When _____ Where _____

Are you considering doing harm to yourself or others? Yes ____ No ____

General History:

Do you feel any part of your sexuality is unhealthy or out of control? _____

_____

Are you currently sexually active? Yes ____ No ____

Did you move a lot as a child? Yes ____ No ____

Where did you grow up?_____

How would you describe your spiritual life?_____

_____

Who do you currently use for social/emotional support?_____

_____

Describe traumas or losses in your life_____

_____

_____

_____

Family History:

Parents Marital Status _____

Siblings No. of Sister/s_____ Age of Sister/s_____

No. of Brother/s_____ Age of Brother/s_____

Check all that apply to your childhood:

__ Happy childhood __ Bullying __ Rebellion

__ Unhappy childhood __ Fears __ School problems

__ Abuse __ Memory blanks __ Sexual molestation

__ Bed wetting __ Nightmares __ Stammering/stuttering __ Other_____

In terms of emotions and relationships, how would you describe the family you grew up in?

_____

_____

_____

Father's Name: _____Age: _____Occupation:_____

Health: _____

Mother's Name: _____ Age: _____Occupation:_____

Health: _____

Have any relatives Parent/s, Sibling/s, Grandparent/s, Uncle/s, Aunt/s, Cousin/s ever had the following conditions. If yes, please circle who:

Substance Abuse or Addiction	☐ Yes	☐ No	(Parent/s)	(Sibling/s)	(Grandparent/s)	(Uncle/s)	(Aunt/s)	(Cousin/s)
Depression	☐ Yes	☐ No	(Parent/s)	(Sibling/s)	(Grandparent/s)	(Uncle/s)	(Aunt/s)	(Cousin/s)
Suicidal Thoughts	☐ Yes	☐ No	(Parent/s)	(Sibling/s)	(Grandparent/s)	(Uncle/s)	(Aunt/s)	(Cousin/s)
Suicide Attempts	☐ Yes	☐ No	(Parent/s)	(Sibling/s)	(Grandparent/s)	(Uncle/s)	(Aunt/s)	(Cousin/s)
Completed Suicide	☐ Yes	☐ No	(Parent/s)	(Sibling/s)	(Grandparent/s)	(Uncle/s)	(Aunt/s)	(Cousin/s)
Anxiety	☐ Yes	☐ No	(Parent/s)	(Sibling/s)	(Grandparent/s)	(Uncle/s)	(Aunt/s)	(Cousin/s)
Panic Attacks	☐ Yes	☐ No	(Parent/s)	(Sibling/s)	(Grandparent/s)	(Uncle/s)	(Aunt/s)	(Cousin/s)
Learning Disability	☐ Yes	☐ No	(Parent/s)	(Sibling/s)	(Grandparent/s)	(Uncle/s)	(Aunt/s)	(Cousin/s)
A.D.D./A.D.H.D.	☐ Yes	☐ No	(Parent/s)	(Sibling/s)	(Grandparent/s)	(Uncle/s)	(Aunt/s)	(Cousin/s)
Developmental Disorder	☐ Yes	☐ No	(Parent/s)	(Sibling/s)	(Grandparent/s)	(Uncle/s)	(Aunt/s)	(Cousin/s)
Schizophrenia	☐ Yes	☐ No	(Parent/s)	(Sibling/s)	(Grandparent/s)	(Uncle/s)	(Aunt/s)	(Cousin/s)
Bipolar	☐ Yes	☐ No	(Parent/s)	(Sibling/s)	(Grandparent/s)	(Uncle/s)	(Aunt/s)	(Cousin/s)
Eating Disorder	☐ Yes	☐ No	(Parent/s)	(Sibling/s)	(Grandparent/s)	(Uncle/s)	(Aunt/s)	(Cousin/s)
Sexual Addiction	☐ Yes	☐ No	(Parent/s)	(Sibling/s)	(Grandparent/s)	(Uncle/s)	(Aunt/s)	(Cousin/s)
Arrests	☐ Yes	☐ No	(Parent/s)	(Sibling/s)	(Grandparent/s)	(Uncle/s)	(Aunt/s)	(Cousin/s)
Domestic Violence	☐ Yes	☐ No	(Parent/s)	(Sibling/s)	(Grandparent/s)	(Uncle/s)	(Aunt/s)	(Cousin/s)

Substance Use & Legal History:

Do you smoke? Yes ____ No ____ Packs per day ____

How often did you have a drink containing alcohol in this past year? (CHECK ONE)
____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 did you have on a typical day when you were drinking in the past year? (CHECK ONE)
____0 drinks
____1 to 2 drinks
____3 to 4 drinks
____5 to 6 drinks
____7 to 9 drinks
____10 or more drinks

How often did you have 5 or more drinks on one occasion in the past year? (CHECK ONE)
____Never
____Less than monthly
____Monthly
____Weekly
____Daily or almost daily

Have you used a drug in the past 30 days that was NOT prescribed by a doctor (for example, marijuana, hash, cocaine, Adderall, diet pills, ecstasy, valium, LSD, acid, mushrooms, heroin, Vicodin, codeine or other)? (CHECK ONE)
_____No
_____Yes

Are you currently or have you in the past been involved in any legal or court proceeding?_____

Have you ever been mandated for treatment?_____

Why Are You Here?

What is the reason you are seeking psychotherapy services?_____

Why did you decide to seek help now?_____

What is your goal in coming here?_____

How long have you had your current problem?_____

What would be a sign that you are getting on track?_____

Why Are You Here? (continued)

What specifically do you want to change about yourself?_____

_____

_____

Use several different words to describe your general personality style:_____

_____

_____

How strongly do you desire treatment for your problems? (circle number)

1 2 3 4 5 6 7 8 9 10

Not very much *Very much*

To what degree has your issue disrupted your life? (circle number)

1 2 3 4 5 6 7 8 9 10

Not very much *Very much*

Some concerns people bring to psychotherapy are listed below. Please check all that apply to you.

1. Relationship Concerns: Friends, Roommates ____
2. Relationship Concerns: Dating, Intimate ____
3. Feeling Depressed or Unhappy ____
4. Feeling Anxious or Nervous ____
5. Increased Level of Energy or Activity ____
6. Concerned about my Alcohol or Drug Use ____
7. Thinking of Killing Myself ____
8. Thinking of Hurting Someone Else ____
9. Family Concerns ____
10. Academic Concerns ____
11. Sexual Concerns ____
12. Religious or Spiritual Concerns ____
13. Financial Difficulties ____
14. Not adjusting well to a new situation ____
15. Worry about my Eating Habits ____
16. Change in Appetite/Eating Habits ____
17. Feeling Lonely ____
18. Upset by a Recent Death ____
19. Strange Experiences, Voices, or Odd Thoughts ____
20. Unsure about my Future Plans ____
21. Concern about Medical Problem/s ____
22. Low Self Esteem ____
23. Sleep Changes/Disturbances ____ If yes, hours of sleep per day ____
24. Anything else you would want us to know not listed above (please specify) _____

    _____

    _____

Please list the corresponding numbers above of your three main concerns:

1. _____ 2. _____ 3. _____

Consent for Treatment

SERVICES: I understand Counseling And Psychological Services (CAPS) offers "**time limited**" therapy provided by either a Licensed Psychologist; Licensed Clinical Social Worker; Associate Social Worker; Master of Social Work Intern; Marriage and Family Therapist Trainee; Marriage and Family Therapy Associate, or Licensed Marriage and Family Therapist, or a Psychiatrist. Trainees, associates and interns are supervised by a Licensed Clinical Social Worker and if treatment is provided by a trainee, associate or intern, I understand pertinent therapy information will be discussed with a supervisor.

I understand individual therapy is generally once a week for a 50 minute appointment and the fee is $5 for undergraduate students or $10 for graduate students (if not on scholarship) during the Fall or Spring semesters, and psychiatric service fee is $25 for the intake session and $10 for a follow-up session.

I understand that therapy may be provided in a remote electronic platform, as telecounseling or as telemedicine for psychiatric services, when appropriate or when necessary to ensure the health & safety of all parties.

Because there is a limited amount of therapy appointments available, I agree to keep my scheduled appointment(s) and if unable to, I understand I must follow the cancellation policy and cancel with at least a 24 hour notice to avoid the fee of $25 for a therapy appointment or $50 for a psychiatric appointment**. I understand that payment is due at the time of service or when the cancellation fee is determined and I am in agreement to have my CUI Student Account charged if payment is not made**. If I cancel an appointment, I understand CAPS staff will attempt to reschedule another appointment. However, if after missing an appointment without contacting the Wellness Center office to schedule another appointment, it will be assumed that I have discontinued therapy with CAPS.

ELIGIBILITY: I understand that I must be a CUI student currently enrolled in at least 6 units to be eligible for services provided by CAPS during open hours, Monday-Friday, 9 am-4 pm (3 pm is the last appointment) with the exception of all holidays and student breaks. I understand that all therapy cases are terminated at the end of each semester and referrals are given.

APPROPRIATENESS AND REFERRALS: I understand that the delivery of services from this agency to me shall be contingent upon whether the CAPS staff and I can agree that the services are appropriate, given the needs and conditions I present. If it is decided that this is not the appropriate agency to meet my needs, I understand that I will be given referrals to resources more appropriate to my needs and goals.

CONFIDENTIALITY: I understand that confidentiality will be held and released in accordance with laws which regulate the confidentiality of records and information. I understand that all information disclosed within a session is confidential and may not be revealed to anyone outside the Wellness Center office without my written permission.

<u>The exception is in situations where disclosure is required by law</u>:

1. If you are thought to be a danger to yourself or others;

<u>The exception is in situations where disclosure is required by law (continued)</u>:

2. When there is an indication of abuse of a child or dependent adult;

The following provides an explanation of our duties as they pertain to the abuse or neglect of children.

a) If you were abused (physically or sexually) or neglected as a child, and if other minor children are currently at risk of being abused or neglected by the person(s) who abused you, this information may need to be reported to the appropriate child protective services agency.

b) If you are under 18 years of age and disclose physical or sexual abuse to your therapist this information must be reported to the appropriate child protective services agency. If you report emotional abuse or neglect, this information may be reported to the appropriate child protective services agency.

c) If you have physically or sexually abused a minor child, and that child, or other minor children are at risk of ongoing abuse, this information may need to be reported to the appropriate child protective services agency.

3. If you have or are engaged in preparing, selling, accessing, streaming, downloading, viewing and/or distributing material of a minor (i.e., person under age 18) engaged in "obscene" acts, including modeling the act or posing for a photograph/video, painting or drawing of an obscene act, including "sexting;"

4. If you become gravely disabled;

5. By court subpoena.

The Dean of Students may be notified if there are any concerns about being a danger to myself or others. *Information disclosed to the Dean of Students will only be limited to the current situation involving your safety or the safety of others. If we are concerned about your safety and would like you to come into the Wellness Center, we may ask that the RD or Campus Safety staff walk you down the Wellness Center. Information that is disclosed to the RD or Campus Safety during this current situation will be limited to information about your safety or the safety of others.*

*____ (Initial Here)

COMMUNICATION: I am providing consent for CAPS staff to contact me by email or telephone and acknowledge that these are not secured modes of communication and/or data transmission of which may contain my personal identifiable and/or protected health information. I am in agreement that my personal information may be used or disclosed in accordance to law, within licensing regulations; including but not limited to treatment, payment, or for CAPS healthcare operations. I also understand that it is the responsibility of all parties involved to take all reasonable actions to protect from non-authorized disclosure. I will let CAPS staff know, in writing, of changes to my contact information and/or preferences.

1) E-mail: I understand CAPS cannot ensure my messages will be received or responded to if my therapist is **not** available.

2) Telephone: I understand that messages may be left at the telephone number I have listed as my main contact number.

3) I understand email or leaving telephone messages are not the appropriate way to communicate **confidential**, **urgent**, or **emergency** information and I am to call the Wellness Center's main desk (949) 214-3102 during open hours. If I have urgent needs when the office is closed, I can call Security at (949) 214-3000, or call 911, or go to my local hospital emergency room.

Notice To Clients: The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of clinical social workers and marriage and family therapists. You may contact the board online at www.bbs.ca.gov or by calling (916) 574-7830.

The Director of Counseling and Psychological Services of the Wellness Center receives and responds to complaints regarding the practice of psychotherapy by any unlicensed or unregistered counselor providing services at Concordia University Irvine. To file a complaint contact Rebecca Kindreich, LCSW at (949) 214-3104; Rebecca.kindreich@cui.edu; 1530 Concordia West, Irvine, CA 92612.

Unless otherwise indicated, I have voluntarily chosen to seek services at CUI Counseling and Psychological Services (CAPS) and may terminate treatment at any time. I understand I have the right to be informed of the various steps and activities involved in receiving services, the right to humane care and self-determination, the right to make an informed decision regarding my participation and services, and the right to seek other psychological services and select practitioners of my choice and at my expense.

I understand the above mentioned information and authorize CUI Counseling and Psychological Services to treat, and/or refer me to others as needed.

Student Signature _____ Student ID# E00_____

Print Name _____ Date_____/_____/_____