Office of Counseling and Disability Services
CLIENT INFORMATION

WHO IS ELIGIBLE FOR SERVICES:
Graduate and undergraduate students currently enrolled for six or more credit hours.
Students who are currently enrolled for fewer than six credit hours may receive some services as available.

WHAT YOU MAY EXPECT FROM US:
✓ You will receive an intake appointment within a reasonable time after contacting us. Your intake therapist will listen to your concerns, and with your help determine the services that are most appropriate for your needs.
✓ In providing short-term therapy the sessions are limited to 10 sessions per semester. If your therapist determines that we cannot best serve your needs, we will assist you in finding appropriate services.
✓ We will answer all your questions about the therapy process as honestly and completely as we can and encourage you to discuss any concerns/questions you may have with your therapist.
✓ We may ask you to evaluate the services you receive from us in order for us to do our best in meeting the needs of our clients.
✓ We reserve the right to defer treatment where in our opinion it would not be within the scope of short-term therapy (as an example, litigation or severe psychiatric issues)
✓ We will make every effort to keep scheduled appointments and will contact you if a change in appointment time is necessary.
✓ We will address emergency situations and crises as quickly as possible.

WHAT WE EXPECT OF YOU:
✓ That you comply with agreed upon treatment plans and fully engage in the treatment process. Should you choose not to, we reserve the right to discontinue treatment.
✓ That you ask any questions you may have about our policies and procedures, or your therapy.
✓ That you keep you scheduled appointments or notify us at least 24 hours in advance if you wish to cancel your appointment. Missed appointments interfere with your progress in therapy and use time which could be scheduled for other clients. Two consecutive missed appointments will result in the closing of your file and further requests for services will need the approval of your therapist.
✓ That you cannot be more than 15 minutes late to your appointment. We ask that you notify us if you are going to be late to any appointment. If you are more than 15 minutes late your appointment will be cancelled and listed as a NO-SHOW. Two no-show appointments qualifies for denial of services.
✓ That you talk with your therapist if you feel that therapy is not meeting your needs, if you decide to discontinue therapy or if you want a referral to another therapist/healthcare provider.

INFORMED CONSENT/CONFIDENTIALITY NOTICE:
The State of New Mexico legally recognizes that communication between a counselor and his/her client is privileged and confidential. We will not disclose your contacts with us to your spouse/partner, your parents, professors, or anyone else without your permission. There are few narrow exceptions:

- If you are in imminent danger to yourself or are a significant danger to someone else, we have a legal obligation to break confidentiality to protect you and/or others.
- Your records can also be subpoenaed by a court of law (e.g. if you claimed emotional damages in a lawsuit).
- If you are abusing children or vulnerable adults or inform us concerning someone who is, then we have legal responsibility to report this to the proper authorities. Such a report could potentially lead to disclosure of your being a client and require testimony concerning the suspected abuse.
- If, as part of an employment process or security screening, you sign a release of records form about services received from us, we will ask that you sign our form to ensure that you are freely and knowingly releasing a brief summary of your contact with us.
- We also reserve the right to consult with your primary care provider at the NMT Health Center when professionally appropriate.

EMERGENCY CONTACTS:
Please call Campus Police – 575.835.5434 / 911
Socorro Mental Health – 575.835.2444
During normal business hours please call 575.835.6619
Office of Counseling & Disability Services

CLIENT INFORMATION

Please fill out this form completely and bring to your first appointment. During your intake appointment, your therapist will discuss this information with you.

Date: _______________________________

Banner ID#: _________________________

Name: ______________________________ Age: _______ DOB: ___/___/____ Gender: □ Male □ Female
(Last) (First) (MI)

Marital Status: □ Never Married □ Partnered □ Married □ Separated □ Divorced □ Widowed
PO Box C/S #: ____________________ Campus/ Off Campus Address: ______________________________

Home Address: ______________________________

Home Phone: (_____)_________________ May we leave a message? □ YES □ NO

Cell Phone: (_____)_________________ May we leave a message? □ YES □ NO

Email Address: ______________________________ May we email you? □ YES □ NO
*please be aware email may not be confidential. *appointments and reminders are sent via email

Whom may we contact in case of emergency? ______________________________ Phone: __________________________ Relationship: __________________________

Do we have your permission to speak with this person only in the event of an emergency? □ YES □ NO

LIVING SITUATION:

While at school I live: □ Alone □ with parents □ with roommates □ spouse/significant other □ other __________________________

How many roommates do you have? _______ __________________________

How would you describe this relationship? ____________________________________________________________________________
____________________________________________________________________________

How long have you lived in Socorro? _____________________________________________

Where did you live prior to living in Socorro? ________________________________________

ENROLLMENT INFORMATION:

Are you a degree seeking student? □ YES □ NO

Year in School: □ Freshman □ Sophomore □ Junior □ Senior □ Graduate

Student Status: □ Full-time □ Part-time □ Other

DEMOGRAPHIC INFORMATION: (optional)

Ethnicity: □ American Indian/Native American □ Asian □ Bi-Ethnic □ Black/African American □ Hispanic/Latino □ White/Anglo □ Other (specify) ________________

Gender Identity: □ Male □ Female

Sexual Identity: □ Bi-sexual □ Gay □ Lesbian □ Straight/heterosexual

REFERRAL INFORMATION:

Who referred you to see us? □ Self □ Faculty/Advisor □ Friend □ Graduate Dean

Residence Halls □ Student Health Center □ Dean of Students □ Other ________________

PERSONAL INFORMATION

Do you have children? □ YES □ NO

Date of Birth: __________________________

EMPLOYMENT INFORMATION:

Are you employed? □ YES □ NO Hours per week you work: ______________ Do you work more than one job? □ YES □ NO

Where do you work? ____________________________________________________________________________

Are you attending your job on a regular basis? □ YES □ NO If no, why? ____________________________________________________________________________
ACADEMIC INFORMATION:
Is this your first semester at NMT? □ YES □ NO
Date of first semester at Tech: ______________________ Are you a transfer student? □ YES □ NO
If yes where did you transfer from? _________________________________________________________________
Have you been attending classes on a regular basis? □ YES □ NO
Has your academic performance changed in the last semester? □ YES □ NO. If yes, how so and why? _________________________________________________________________
Are you on academic probation/suspension? □ YES □ NO Are you on Financial Aid probation/suspension? □ YES □ NO
Major area of study: ____________ Advisor: ____________
Current GPA? ___________________ Amount of Credits Attempting: __________________________

PHYSICAL HEALTH INFORMATION:
What is the status of your health? □ Excellent □ Fair □ Poor □ Poor Date of last physical: ____________
Do you have a primary care provider? □ YES □ NO Allergies: _______________________________________
If yes, what is his/her name and address? __________________________________________________________
Reason for medical care: ____________________________________________________________
List any current/previous medications/supplements prescribed ______________________________________________
I have tried to control my weight (in the past 12 months) with:
□ Diet pills □ Excessive exercise □ Not eating □ Other ____________
□ Diuretics □ Laxatives □ Vomiting ____________
□ I have not tried to control my weight (in the past 12 months) _____________________________________________

MENTAL HEALTH HISTORY:
Have you been a client of this office before? □ YES □ NO, If so when? ____________________________________
Have you been in therapy or counseling before? □ YES □ NO, If so when? And with whom? ______________
Did you receive a diagnosis? □ YES □ NO, Please describe: ____________________________________________
Are you currently taking any medication? □ YES □ NO, If yes, please describe __________________________________
Have you been prescribed medication in the past? □ YES □ NO, If yes, please describe ____________________________
Have you ever been hospitalized for a psychological problem? □ YES □ NO, Please describe (Please include dates) _________________________________________

I have specific thought/plans of killing myself: I have specific thoughts/plan of killing others:
□ Recently (in the last 5 – 7 days) □ Recently (in the last 5 – 7 days)
□ In the past □ In the past □ Never □ Never
(less than □ less than □ Never
a year ago) □ more than □ (more than
a year ago) □ (more than
□ At times I have acted in a violent manner. □ I am dissatisfied with my personal appearance.
□ I have been in trouble with the legal system. □ Sometimes I hear strange voices in my head or see
□ My social/dating life is not satisfactory □ things that might not be real.
□ There are sexual concerns I’d like to discuss. □ Sometimes I don’t know where I am.

Do you feel like you are being abused or have been abused? □ YES □ NO Please describe: ____________________________

PLEASE CHECK ALL OF THE FOLLOWING THAT APPLY
My family has a history of:
□ Alcohol/drug abuse □ Depression □ Parents: Divorced/Separated □ Family Suicide
□ Attention Deficit Disorder □ Eating Disorder □ Physical/sexual abuse □ Mental Health History
□ Counseling/Therapy □ Hospitalization □ Poor communication □
□ My family is not emotionally close □ I cannot talk to my family about personal issues
□ My relationship with my family is not satisfactory □ I am close to my family and have a good relationship with them
I AM EXPERIENCING PROBLEMS IN THE FOLLOWING AREAS: (Please check all that apply)

- Academic
- Childcare
- Conflict with roommate/friends
- Conflict with significant other(s)
- Expressing emotions
- Recent loss due: ___ death ___ relationship ___ job termination

As a result of the stressors, I have problems with:

- Anxiety/Panic Attacks
- Concentration
- Mood shifts
- Weight Loss/Gain
- Relationships
- Appetite/Fatigue
- Headaches
- Sleeping
- Energy/motivation
- School
- Depression
- Hallucinations
- Loss of Interest
- Avoidance
- Crying Spells

SUBSTANCE HISTORY

Have You Tried or Are Currently Using the Following (Check All That Apply)

<table>
<thead>
<tr>
<th>Alcohol</th>
<th>Tobacco</th>
<th>Heroin</th>
<th>Ecstasy</th>
<th>Methamphetamine</th>
<th>Methadone</th>
<th>Marijuana</th>
<th>Cocaine</th>
<th>Tranquilizers</th>
<th>Hallucinogens</th>
<th>Stimulants (Pills)</th>
<th>Rx Pain Killers</th>
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</table>

Other drugs tried/currently using (please describe):

Have you ever been treated for drug/alcohol abuse? □ YES □ NO If yes, please provide dates: ______________________________

For which substances:

Have you ever abused any kind of prescription medications? □ YES □ NO If yes, which ones: ______________________________

Do you drink caffeinated beverages? □ YES □ NO If yes, how many per day: ______________________________

Do you take any kind of substance to help keep you awake? □ YES □ NO If yes, please describe: ______________________________

I would like information on quitting smoking, using drugs, prescription medication or alcohol. □ YES □ NO

THE FOLLOWING HAVE RESULTED FROM MY ALCOHOL/DRUG USE (in the past 12 months)

- Academic problems
- Blackouts
- DWI
- Fighting
- Nothing significant
- Ruined relationships
- Traffic violations
- NMT disciplinary action
- Other (specify): ______________________________
- Constant pain

HEALTHY ALTERNATIVES (Check All That Apply)

<table>
<thead>
<tr>
<th>Exercise</th>
<th>Outdoor Activity</th>
<th>Walking</th>
<th>Drink Water</th>
<th>Eat Balanced Meals</th>
<th>Sleeping Well</th>
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</thead>
<tbody>
<tr>
<td>Occasionally</td>
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PLEASE DESCRIBE WHAT BRINGS YOU IN TODAY?

______________________________________________________________________________________________________________

______________________________________________________________________________________________________________

______________________________________________________________________________________________________________

______________________________________________________________________________________________________________

______________________________________________________________________________________________________________
Limits of confidentiality

The State of New Mexico legally recognizes that communication between a counselor and her/his client as privileged and confidential. Your mental health records do not become part of your educational records. We will not disclose your contacts with us to your spouse/partner, your parents, professors, or anyone else without your permission. There are few narrow exceptions:

- If you are in imminent danger to yourself or are a significant danger to someone else, we have a legal obligation to break confidentiality to protect you and/or others.
- You records can also be subpoenaed by a court of law (e.g. if you claimed emotional damages in a lawsuit).
- If you are abusing children or vulnerable adults or inform us concerning someone who is, then we have a legal responsibility to report this to the proper authorities. Such a report could potentially lead to disclosure of your being a client and require testimony concerning the suspected abuse.
- We also reserve the right to consult with your primary care provider at the NMT Health Center, and other mental health professionals when appropriate.
- It is the policy of NM Tech Office of Counseling and Disability Services to involve the Behavior Intervention Team, Dean of Students, and/or Residential Life if there is a pressing safety issue.

Emergency Contact

By providing us with an emergency contact (page 1) you have given us permission to contact this/these person(s) if an emergency arises in regards to your health safety.

I have read and understand the limits of confidentiality.

Client Signature ________________________________ Date ________________________________

Therapist Signature ______________________________ Date ________________________________

Revised 06/16