

University of Central Arkansas

Counseling Center

Student Health Center – Suite 327

Conway, AR 72035

(501) 450-3138

UCA Counseling Center Client Information

Eligibility: Counseling services of the Center are available to all currently registered students, faculty, and staff members at the University of Central Arkansas. Students include all part-time and full-time students enrolled in undergraduate and graduate programs. The spouse/partner of UCA students, faculty and staff may only be seen for couples counseling.

Intake Interview: All clients are scheduled for an initial interview (intake) with a Counseling Center staff member. The purpose of the intake interview is to gather information about the client, his/her concerns, background data, contributing factors to current problems, and goals for counseling. Further, the intake interview is used to identify those clients who can benefit from Counseling Center services and those who should be referred elsewhere.

Client Assignment: Client assignments are made in one of three ways. (1) The intake counselor requests approval from the Clinical Coordinator to work with the client he/she has seen. (2) The Clinical Coordinator reviews the client file after the intake session and either makes or approves an assignment to a senior staff, intern or a Master's level trainee. (3) A client may request a particular counselor. Assignments are based on compatibility of staff/client, client requests and staff availability.

Counseling Sessions: The Counseling Center uses a brief counseling model. We have established a limit of 10 sessions of individual counseling, per client, in a one year period. The intake session is not included in the 10 sessions. Brief counseling has several important features: (A) The focus is on identifying specific and attainable goals; (B) Attention is given primarily to the present rather than the past; and (C) Both counselor and client are active; homework assignments are commonly used. Ten sessions or less is sufficient for most clients. For those who want additional counseling, or require more intensive work, the Counseling Center will provide referral options that are available locally. A counseling session is typically 50-60 minutes in length and sessions are commonly scheduled on a once/week basis.

Groups: Some clients can also benefit from group counseling. A variety of groups are offered each semester. There is no limit, for most groups, on the number of sessions a student may attend at the Counseling Center.

Cancellations & Missed Appointments: It is important that the client arrive on time for his/her appointment. If the client is not going to keep a scheduled appointment, (e.g. due to illness, absence from school, no longer wants counseling) we ask that the client call the Counseling Center and cancel the appointment at least 24 hours in advance at which the time the client will be asked whether or not he/she wants to reschedule.

Cancellations & Missed Appointments (continued):

When a client fails to contact the Counseling Center to cancel an appointment, he/she is considered to be a “No Show”. Please be considerate in scheduling because that appointment time, reserved by the counselor for you, could be used to serve another client.

Clients, including No Shows, who reschedule but do not attend two consecutive sessions may have their files closed for the semester and not be permitted to return to counseling until the next semester. Clients who arrive more than 15 minutes late for their appointment will be seen or rescheduled at the discretion of the counselor.

Concerns and Complaints: The Counseling Center staff strives to provide counseling that demonstrates respect for every client, treats all with dignity, and is sensitive to the diversity that is present in those whom we serve. If your counselor does not meet these standards in counseling with you then we encourage you to let us know.

First, you may take your concern directly to your counselor and attempt to resolve the issue/s with him/her. If that interaction does not result in a satisfactory solution - or you are uncomfortable speaking directly with your counselor about your concern - then request to speak with the Director of the Counseling Center (501-450-3138; Student Health Center, Suite 327). The Director will arrange a meeting with you to review the issue/s and attempt to find a suitable resolution.

If the Director of the Counseling Center is your counselor and your complaint is about her, you may contact the Vice President for Student Services (501-450-3416; Student Health Center, Suite 210). He will arrange a meeting with you to review the issue/s and attempt to find a suitable resolution.

University of Central Arkansas

Division of Student Services

The mission of the Division of Student Services is to challenge, support, and encourage our students by providing innovative services, programs, facilities, and resources in order to maximize the collegiate experience.

UCA Counseling Center Confidentiality Policy

Confidentiality is an ethical standard that protects clients from the disclosure of information without their consent. Client contacts with the Counseling Center are confidential. We will not provide information about clients to friends, partners, faculty, parents, employers or anyone else outside of the Counseling Center Staff. Information may be exchanged between the UCA Counseling Center, the UCA Student Health Clinic, and Disability Support Services without requiring client consent, when those offices are providing services for the same client.

The Counseling Center will release information from counseling sessions to third parties only at the request of the client. The "Authorization to Release Professional Information" form, signed by the client and a witness, will be used for that purpose. The client must give informed consent and therefore his/her counselor will discuss, prior to release, the information to be released, to whom, and for what purpose. The client will also be advised about the possible effects of disclosure.

Exceptions:

- When the Counseling Center believes that a client poses a clear and present danger of harm to himself/herself and/or others, the Counseling Center may selectively release information, without the client's consent, to aid in the care and protection of the client or endangered others.
- When the Counseling Center has reasonable cause to suspect that a child (a person under 18 years of age) has been subjected to child maltreatment, which may involve abuse, sexual abuse, neglect, sexual exploitation or abandonment as defined by Arkansas Law, the Counseling Center may selectively release information, without the client's consent, to aid in the care and protection of a child. The Counseling Center is further required by Arkansas Law to report this information to the Department of Human Services.
- When the Counseling Center has reasonable cause to suspect that an adult (a person 18 years of age or older) through abuse or neglect, is in imminent risk of death, or bodily harm and does not comprehend the nature and consequence of remaining in that situation or condition, then the Counseling Center is required to report this situation to the Arkansas Department of Human Services.

E-mail Communication:

E-mail is an important means of communication. However, e-mail is not a secure means to transmit confidential information. Therefore, the Counseling Center will use e-mail to communicate with clients only (a) in response to the client's initiation and (b) with the client's consent to send messages to their e-mail address. Copies of e-mail communication between client and counselor will be scanned into the client's file.

Client files:

The Family Educational Rights and Privacy Act of 1974 (FERPA) provides that students records maintained by physicians, psychologists, psychiatrists or other recognized professionals and para-professionals are not educational records. Therefore, client files do not become part of any permanent record at the University, but are the property of the Counseling Center. A client's file is maintained at the Counseling Center for a period of seven (7) years from the date of last contact. A client's file is destroyed after this seven (7) year period.

Clients may review their records in the presence of a Counseling Center staff member, upon written request. The request and fact that a review occurred will be noted in the client's record. Clients may receive copies of their record unless the Counseling Center, upon review, believes disclosure would be detrimental to the client's health or well-being.

The client file of a person who is not a student, including but not limited to, a staff member, faculty member, student's spouse, etc., is not an educational record.

Client session notes are kept and stored electronically and maintained in the client's file. The entire file including client demographic information and other personal information is maintained electronically in a secured server dedicated to the Counseling Center's needs. Compiled information when retrieved is used for summary report purposes and does not identify clients by name.

Disclosure of Client Records:

Arkansas law recognizes the privilege that attaches to the counselor-client and psychologist-client relations. The privilege is extended only to licensed counselors and psychologists. Should the Counseling Center receive a subpoena for client records, university legal counsel will be consulted prior to taking any action. Clients will be notified in advance, if at all possible, of any compliance with a court order, state or federal law that might require disclosure of client records.

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Informed Consent for Personal Counseling

I, _____, have voluntarily decided to seek personal counseling from the UCA Counseling Center. I understand the following points about the treatment I will receive:

- 1) The treatment that I receive is considered confidential. I have been informed about the exceptions to confidentiality and presented with a full copy of the UCA Counseling Center's confidentiality policy.
- 2) Services are provided by staff members who are licensed psychologists, psychological examiners, and counselors as well as graduate trainees. I will be informed if I am being seen by a graduate trainee as well as the identity of his/her supervisor. Staff member credentials are kept on file and I may request to view those of my counselor.
- 3) The staff member who provides my personal counseling will offer treatment that is within the scope of his/her competence to provide.
- 4) Treatment will be based upon the particular issues, concerns, or problems which the staff member and I agree to work on.
- 5) Treatment goals are therapeutic in nature. If I have issues that have resulted in **court-ordered** counseling, have legal implications, and/or require formal evaluation, then I will be referred to off-campus mental health professionals for relevant services.
- 6) No formal diagnosis will be made by the staff member.
- 7) The treatment will consist of methods (strategies, techniques, and interventions) that are generally accepted in the mental health field as appropriate for the problems that I present. When there are limitations or foreseeable harm that could occur with a specific method, the staff member will explain them to me.
- 8) The staff member believes the proposed treatment can improve my condition and enable me to achieve my goals but he/she cannot guarantee the results.
- 9) The staff member may recommend that I complete a psychological test/inventory as a component in my treatment. He/she will explain the purposes and uses of the test(s). I may choose whether or not to take them. The staff member will provide an interpretation of the results for any test that I complete.
- 10) There is no direct charge or cost for treatment services.
- 11) I, as the client, will not be forced to continue with the proposed treatment. I can choose to discontinue my personal counseling at any time.
- 12) I have been presented with the "UCA Counseling Center Client Information" sheet that defines other pertinent information about practices and procedures.

Upon consideration of the information presented to me, I authorize the staff member to provide me with personal counseling and to use the methods that he/she believes clinically appropriate. I make this decision to accept the proposed treatment knowingly, voluntarily, and without coercion.

Signed: _____

Date: _____

(10/12)

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Consent to Audiotape/Video/Observe Counseling Sessions

The Counseling Center, among its functions, serves as a teaching-training center for Masters-level graduate students. Each student is individually supervised by a professional staff member. The supervision, in part, allows us to see that every client is being provided with competent counseling.

You may be assigned to a Masters-level graduate student for your counseling sessions. Audio taping, video recording and live observation of the sessions are a significant component to their training. Therefore, we use this consent form to obtain your permission to audiotape, video and/or observe. Feel free to ask your intake counselor any questions about the purposes of taping and use of the tapes.

____ Yes, you have my permission to audiotape my counseling sessions.

____ Yes, you have my permission to video record my counseling sessions.

____ Yes, you have my permission to have a professional staff member observe my counseling sessions.

I understand that:

- I may withdraw this consent at anytime.
- I may request that the tape recorder or video recorder be turned off at any time and may request that the tape or any portion thereof be erased.
- The purpose of taping is for use in training and supervision. The supervisor may listen/view some/all of the tape. The tape will be erased after supervision.
- Tapes are stored in a secure location within the Counseling Center.
- These tapes may not be used for any other purpose without my explicit written permission.
- My receiving counseling services will not be affected if I do not give permission to tape or observe.

____ No, I would like to discuss this further with my counselor.

Signature

Date

____ After further discussion with my counselor, I hereby give my permission for taping/observing.

____ Audio Taping ____ Video Recording ____ Observe

Signature

Date

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CONFIDENTIAL INFORMATION SHEET

DATE: _____

NAME _____ UCA ID # _____
Last First M.

Current (School) Address _____

City _____ State _____ Zip _____

Cell Phone _____

Alternate Phone (Whose #?) _____

Permanent (home) Address _____

City _____ State _____ Zip _____

Email _____

May we **CONTACT** you at:

Cell Phone? yes _____ no _____
Alternate Phone? yes _____ no _____
Email? yes _____ no _____

May we leave a **MESSAGE** on your:

Cell Phone? yes _____ no _____
Alternate Phone? yes _____ no _____

Please circle the times you are **AVAILABLE** to meet with a counselor:

Monday	Tuesday	Wednesday	Thursday	Friday
8:00 12:00	8:00 12:00	8:00 12:00	8:00 12:00	8:00 12:00
9:00 1:00	9:00 1:00	9:00 1:00	9:00 1:00	9:00 1:00
10:00 2:00	10:00 2:00	10:00 2:00	10:00 2:00	10:00 2:00
11:00 3:00	11:00 3:00	11:00 3:00	11:00 3:00	11:00 3:00
4:00	4:00	4:00	4:00	4:00

1. **Gender:** Male _____ Female _____ 2. **Age:** _____ **Date of Birth:** _____

3. **Race/Ethnic Background:** Asian/Pacific Islander _____ Black/African American _____ Hispanic _____
Native American/Alaskan Native _____ White/European American _____
Bi-Racial _____ (_____ / _____)
Other: _____ (_____)

4. **Current Status:** Single _____ Engaged _____ Married _____ Divorced _____
Separated _____ Widowed _____

5. **Children:** Yes _____ No _____ How Many _____
Ages: _____

6. **Classifications:** Freshman _____ Sophomore _____ Junior _____ Senior _____
Graduate Student _____ Faculty _____ Staff _____ Other _____

7. **Major:** _____ 8. **Current GPA:** _____

8. **Are You Currently Employed?** Yes _____ No _____
Average Number Of Hours Per Week: _____

9. **Who Referred You to Counseling?** Self _____
(Did you take the Mental Health Online Screening? Yes _____ or No _____)
Faculty _____ (Name: _____ Staff _____ (Name: _____)
Student Health Clinic _____ Friend _____ Other _____

11. **Previous Counseling Help?** Yes _____ No _____ If yes, name of counselor and/or facility:

12. **Are You Presently Taking Any Medication?** Yes _____ No _____

Prescription? _____

Reason: _____

Prescribed by: Family Doctor _____ Psychiatrist _____ OB/GYN _____

Student Health Clinic _____ Other _____

Over The Counter? _____

Reason: _____

Family Members (Parents and Siblings) / Significant Others (Partner and Children):

Relationship (DO NOT List Name)	Age	Education	Occupation

Please read this list and check the items of concern to you:

- | | |
|---|---|
| <input type="checkbox"/> 1. Can't seem to study effectively | <input type="checkbox"/> 35. Lonely |
| <input type="checkbox"/> 2. Trouble taking tests | <input type="checkbox"/> 36. Difficulty expressing my emotions |
| <input type="checkbox"/> 3. Adjustment to college | <input type="checkbox"/> 37. Feeling Depressed |
| <input type="checkbox"/> 4. Academics/Grades | <input type="checkbox"/> 38. Discouraged about my future |
| <input type="checkbox"/> 5. Learning disability/Attention deficit disorder | <input type="checkbox"/> 39. Feeling inferior |
| <input type="checkbox"/> 6. Parental pressure | <input type="checkbox"/> 40. Afraid of making mistakes |
| <input type="checkbox"/> 7. Unsure of career choice | <input type="checkbox"/> 41. Nobody understands me |
| <input type="checkbox"/> 8. Financial problems | <input type="checkbox"/> 42. Failure or rejection |
| <input type="checkbox"/> 9. Too tired to do much of anything | <input type="checkbox"/> 43. Difficulty making decisions |
| <input type="checkbox"/> 10. Sleep problems | <input type="checkbox"/> 44. Unable to concentrate |
| <input type="checkbox"/> 11. Nightmare (s)/Dreams | <input type="checkbox"/> 45. Sexual Matters |
| <input type="checkbox"/> 12. Headaches | <input type="checkbox"/> 46. Whether or not to stay married |
| <input type="checkbox"/> 13. Loss of appetite | <input type="checkbox"/> 47. Divorce adjustment |
| <input type="checkbox"/> 14. Eating habits/problems | <input type="checkbox"/> 48. Sexual Assault/Rape |
| <input type="checkbox"/> 15. Sudden changes in my personality or behavior | <input type="checkbox"/> 49. Confused about religious beliefs |
| <input type="checkbox"/> 16. Withdrawing from other people | <input type="checkbox"/> 50. Being a nontraditional student |
| <input type="checkbox"/> 17. Feel that others do not like me | <input type="checkbox"/> 51. Uncertain about sexual identity |
| <input type="checkbox"/> 18. Uncomfortable at social gatherings | <input type="checkbox"/> 52. Gay, lesbian, bisexual, transgender |
| <input type="checkbox"/> 19. Difficulty trusting other people | <input type="checkbox"/> 53. Own use of drugs/Alcohol |
| <input type="checkbox"/> 20. Not mixing well with the other sex | <input type="checkbox"/> 54. Another's use of drugs/Alcohol |
| <input type="checkbox"/> 21. No close friend's | <input type="checkbox"/> 55. STD/HIV/AIDS |
| <input type="checkbox"/> 22. Relationship/Marital problems | <input type="checkbox"/> 56. Parental conflict |
| <input type="checkbox"/> 23. Roommate problems | <input type="checkbox"/> 57. Family problems |
| <input type="checkbox"/> 24. Whether or not to get married | <input type="checkbox"/> 58. Abuse: emotional ___ sexual ___ physical ___ |
| <input type="checkbox"/> 25. Too easily influenced by other people | <input type="checkbox"/> 59. Thoughts of suicide: within last 24 hours ___
within last week ___ within last 6 months ___ |
| <input type="checkbox"/> 26. Nervousness | <input type="checkbox"/> 60. Have you had any serious illness or injuries in
your life? If yes, please list: _____ |
| <input type="checkbox"/> 27. Anger | _____ |
| <input type="checkbox"/> 28. Unhappiness | <input type="checkbox"/> 61. Have you tried to control your weight? If yes,
How? Dieting _____ Exercise _____ |
| <input type="checkbox"/> 29. Feeling guilty | Vomiting _____ Laxatives _____ |
| <input type="checkbox"/> 30. Grief/Loss | <input type="checkbox"/> 62. Has there been a death of anyone close to you
in the last five years? If yes, who?
_____ |
| <input type="checkbox"/> 31. Abortion | _____ |
| <input type="checkbox"/> 32. Dissatisfied or bored with most everything | |
| <input type="checkbox"/> 33. Worrying too much | |
| <input type="checkbox"/> 34. Great sense of loss | |
| <input type="checkbox"/> 63. Has any member (s) of your family, other than you: (check all that apply and please specify relationship (s)) | |
| <input type="checkbox"/> been physically/sexually abused by another member _____ | |
| <input type="checkbox"/> been hospitalized for mental disorder _____ | |
| <input type="checkbox"/> had significant problems with alcohol/drugs _____ | |
| <input type="checkbox"/> been imprisoned or trouble with the law _____ | |
| <input type="checkbox"/> been married three or more times _____ | |
| <input type="checkbox"/> had serious medical problems _____ | |
| <input type="checkbox"/> 64. Do you have the desire or need to harm yourself through: | |
| <input type="checkbox"/> cutting <input type="checkbox"/> burning <input type="checkbox"/> severing <input type="checkbox"/> inserting <input type="checkbox"/> hitting | |
| <input type="checkbox"/> constricting <input type="checkbox"/> picking <input type="checkbox"/> other _____ | |

Overall, to what extent is your **academic performance** – concentration, memory, motivation, class attendance, assignment completion – being affected by the problem (s) you want to work on in counseling? Please circle a number on the rating scale.

1	2	3	4	5
No	Slight	Moderate	Much	Major
Effect	Effect	Effect	Effect	Effect

Please state, in your own words, what you would like to discuss with the counselor.

Please read this list and check the behaviors that you have tried in order to cope with your concerns:

- | | |
|--|---|
| <input type="checkbox"/> 1. Talked with at least one family member | <input type="checkbox"/> 9. Changed physical appearance |
| <input type="checkbox"/> 2. Talked with at least one friend | <input type="checkbox"/> 10. Art/Music/Dance |
| <input type="checkbox"/> 3. Talked with partner/spouse | <input type="checkbox"/> 11. Keeping a journal |
| <input type="checkbox"/> 4. Talked with minister | <input type="checkbox"/> 12. Recreational activities/Hobbies |
| <input type="checkbox"/> 5. Prayer/Meditation | <input type="checkbox"/> 13. Read self-help books |
| <input type="checkbox"/> 6. Exercise | <input type="checkbox"/> 14. Worked extra hours/Studied more |
| <input type="checkbox"/> 7. Eating | <input type="checkbox"/> 15. Community service |
| <input type="checkbox"/> 8. Drugs/Alcohol | <input type="checkbox"/> 16. Avoid/Ignore the problems all together |

The Counseling Center offers groups each semester which are opportunities to share common concerns with other students. Would you like to be included on a listserv to receive information about groups? _____ Yes _____ No

If yes, what is your email address?

What are your goals for counseling (i.e., what do you want to occur as a result of counseling)? Please be as specific as possible.

1. _____
2. _____
3. _____