STUDENT INTAKE FORM

Student ID	Date

PERSONAL INFORMATION

First Name	MI	Last Name
Age	Date of Birth	Referred By
Sexual Orientation	Ethnicity	
Insurance Provider -		

CONTACT INFORMATION

Local Address		
City	State	Zip
Phone Number	Cell Phone Number	
SWOSU Email Address		
Hometown/Country		
Last Visit to PCP (Primary Care Physician) -		
Registered with Disability Services? If yes, please describe.		

EMERGENCY CONTACT INFORMATION

First Name	MI	Last Name
Phone Number		
City	State	Zip
Relationship to Student		

ACADEMIC / CAREER INFORMATION

☐ Freshman	☐ Sophomore	☐ Junior	☐ Senior	☐ Graduate
Major/Minor	GPA	Advisor		
Future Plans -				
Employment Status: ☐ Full-Time ☐ Part-Time ☐ Not Employed				
Organized SWOSU Groups/Athletics You Participate In -				

CHWB Student Intake Questions

Presenting Concern

Primary concern (check all that apply):

☐ Anxiety ☐ Depression ☐ Stress ☐ Relationship Concerns

☐ Academic Concerns ☐ Family Concerns ☐ Trauma/PTSD

☐ Other: _____

What brings you to counseling today?

_____

_____

What would you like to be different after counseling?

_____

_____

Counseling & Treatment History

☐ This is my first time receiving counseling services

Have you previously received counseling services? ☐ Yes ☐ No

Approximate dates: _____

Was it helpful? ☐ Yes ☐ No ☐ Somewhat

Previous mental health diagnoses:

_____

Current medications:

_____

Prescribing provider:

_____

Support System

Who are the people you can rely on for support?

_____

_____

Relationship Status:

☐ Single ☐ Dating ☐ Married ☐ Divorced ☐ Other

Basic Needs Screening

In the past 30 days, have you worried about any of the following?

☐ Having Enough Food

☐ Transportation

☐ Paying Bills

☐ Housing Stability

☐ Access to Healthcare

☐ Childcare

☐ None of the Above

Would you like information about campus resources? ☐ Yes ☐ No

Additional Information

Have you served in the military? ☐ Yes ☐ No

Are you a parent/caregiver? ☐ Yes ☐ No

Healthy Lifestyle Screening (Short Intake Version)

Please indicate how often you do the following:

	Never	Sometimes	Often	Routinely
Get enough sleep	1 ☐	2 ☐	3 ☐	4 ☐
Follow a planned exercise program.	1 ☐	2 ☐	3 ☐	4 ☐
Get exercise during usual daily activities.	1 ☐	2 ☐	3 ☐	4 ☐
Eat 2–4 servings of fruit each day	1 ☐	2 ☐	3 ☐	4 ☐
Eat 3–5 servings of vegetables each day.	1 ☐	2 ☐	3 ☐	4 ☐
Eat breakfast.	1 ☐	2 ☐	3 ☐	4 ☐
Discuss my health concerns with health professionals when needed.	1 ☐	2 ☐	3 ☐	4 ☐
Take some time for relaxation each day.	1 ☐	2 ☐	3 ☐	4 ☐
Use specific methods to control my stress.	1 ☐	2 ☐	3 ☐	4 ☐
Maintain meaningful and fulfilling relationships with others.	1 ☐	2 ☐	3 ☐	4 ☐
Get support from a network of caring people.	1 ☐	2 ☐	3 ☐	4 ☐
Believe that my life has a purpose.	1 ☐	2 ☐	3 ☐	4 ☐
Feel content and at peace with myself.	1 ☐	2 ☐	3 ☐	4 ☐

STAFF ONLY

Items scored 1 (Never): ____

Items scored 2 (Sometimes): ____

Total Risk Items (1 or 2): _____ / 13

Interpretation:

- 0–2 = Low concern
- 3–5 = Moderate concern
- 6+ = Consider follow-up discussion

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0 ☐	1 ☐	2 ☐	3 ☐
2. Feeling down, depressed, or hopeless	0 ☐	1 ☐	2 ☐	3 ☐
3. Trouble falling or staying asleep, or sleeping too much	0 ☐	1 ☐	2 ☐	3 ☐
4. Feeling tired or having little energy	0 ☐	1 ☐	2 ☐	3 ☐
5. Poor appetite or overeating	0 ☐	1 ☐	2 ☐	3 ☐
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0 ☐	1 ☐	2 ☐	3 ☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	0 ☐	1 ☐	2 ☐	3 ☐
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	0 ☐	1 ☐	2 ☐	3 ☐
9. Thoughts that you would be better off dead or of hurting yourself in some way	0 ☐	1 ☐	2 ☐	3 ☐

FOR OFFICE CODING *0* **+** _____ **+** _____ **+** _____

=Total Score: _____

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**
☐	☐	☐	☐

General Anxiety Disorder questionnaire (GAD-7)

Over the **last 2 weeks**, how often have you been bothered by the following problems?	Not at all	Several Days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0 ☐	1 ☐	2 ☐	3 ☐
2. Not being able to stop or control worrying	0 ☐	1 ☐	2 ☐	3 ☐
3. Worrying too much about different things	0 ☐	1 ☐	2 ☐	3 ☐
4. Trouble relaxing	0 ☐	1 ☐	2 ☐	3 ☐
5. Being so restless that it is hard to sit still	0 ☐	1 ☐	2 ☐	3 ☐
6. Becoming easily annoyed or irritated	0 ☐	1 ☐	2 ☐	3 ☐
7. Feeling afraid as if something awful might happen	0 ☐	1 ☐	2 ☐	3 ☐
Total score of all your answers: _____				
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 ☐

When did the symptoms begin? _____

_____

ALCOHOL SCREENING TOOL

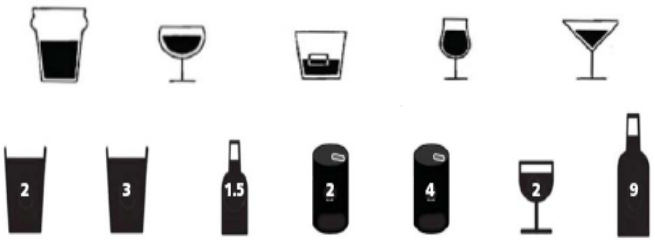
1 unit is typically:

Half-pint of regular beer, lager or cider; 1 small glass of low ABV wine (9%); 1 single measure of spirits (25ml)

The following drinks have more than one unit:

A pint of regular beer, lager or cider, a pint of strong /premium beer, lager or cider, 440ml regular can cider/lager, 440ml "super" lager, 250ml glass of wine (12%)

UNIT GUIDE



The following questions are validated as screening tools for alcohol use

AUDIT- C Questions	**Scoring system**					**Your score**
	0	**1**	**2**	**3**	**4**	
How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1-2 ✓	3-4	5-6	7-9 ✓	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
					TOTAL :	

A score of **less than 5** indicates *lower risk drinking* (see overleaf)

Scores of 5+ requires the following 7 questions to be completed:

AUDIT Questions (after completing 3 AUDIT-C questions above)	**Scoring system**					**Your score**
	0	**1**	**2**	**3**	**4**	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					TOTAL	

STAFF USE ONLY

SCORING: **ADD the 2 scores together to identify necessary action (e.g. Brief Advice)**

AUDIT C _____ + AUDIT _____ = ☐

"Based on your answers, your drinking places you in the … risk category."
(for 8+ scores lead to Brief Advice with) "How do you feel about that?"

AUDIT SCORE	RISK CATEGORY		DESIRED ACTION
0 –7	**Lower risk**	**=**	**No intervention required**
8 –15	**Increasing risk**	**=**	**Brief Advice**
16-19	**Higher risk**	**=**	**Brief Advice and/or extended BA**
20+	**Possible dependence**	**=**	**Referral to services (see below)**

Brief Intervention (IBA) pathway

AUDIT-C
(3 questions)

→ **Where individual scores below 5, no further action required**

Where individual scores 5+, ask remaining 7 AUDIT questions for total score

AUDIT Score 0-7

Congratulate and reinforce benefits of lower risk drinking.

AUDIT Score 8 -15

Brief Discussion- Review AUDIT results with student. Discuss potential health, academic, or social impacts. Explore interest in reducing risk.

AUDIT Score 16-19

Focused Intervention Discuss concerns related to alcohol use. Assess readiness for change. Offer follow-up appointment and campus resources.

AUDIT Score 20+

Requires Further Assessment

Lower risk
This level of drinking means that in most circumstances you have a low risk of causing yourself future harm

Increasing risk
Drinking at a level that increases the risk of damaging your health and could lead to serious medical conditions.

Higher risk
This level of drinking has the greatest risk of health problems.

Where individual does not respond to Brief Advice or wants to discuss further, an 'Extended Brief intervention' (i.e. 20-30 mins motivational interviewing), should be offered.

Drug and Alcohol practitioners or those trained in Motivational Interviewing can deliver a number of 'extended brief interventions'.

SUICIDAL IDEATION

Ask questions 1 and 2. If both are negative, proceed to "Suicidal Behavior" section. If the answer to question 2 is "yes", ask questions 3, 4 and 5. If the answer to question 1 and/or 2 is "yes", complete "Intensity of Ideation" section below.

	Lifetime: Time you Felt Most Suicidal	Past 1 month
Have you wished you were dead or wished you could go to sleep and not wake up? If yes, describe:	Yes ☐ No ☐	Yes ☐ No ☐
Have you actually had any thoughts of killing yourself? If yes, describe:	Yes ☐ No ☐	Yes ☐ No ☐
Have you been thinking about how you might do this? If yes, describe:	Yes ☐ No ☐	Yes ☐ No ☐
Have you had these thoughts and had some intention of acting on them? If yes, describe:	Yes ☐ No ☐	Yes ☐ No ☐
Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan? If yes, describe:	Yes ☐ No ☐	Yes ☐ No ☐

INTENSITY OF IDEATION

The following features should be rated with respect to the most severe type of ideation (i.e., 1-5 from above, with 1 being the least severe and 5 being the most severe). Ask about time he/she was feeling the most suicidal.

Lifetime - ***Most Severe Ideation:*** _____ (***Type # (1-5)***) _____ (***Description of Ideation***)

Recent - ***Most Severe Ideation:*** _____ (***Type # (1-5)***) _____ (***Description of Ideation***)

	Most Severe	Most Severe
Frequency ***How many times have you had these thoughts?*** (1) Less than once a week (2) Once a week (3) 2-5 times in week (4) Daily or almost daily (5) Many times each day	____	____
Duration ***When you have the thoughts how long do they last?*** (1) Fleeting - few seconds or minutes (2) Less than 1 hour/some of the time (3) 1-4 hours/a lot of time (4) 4-8 hours/most of day (5) More than 8 hours/persistent or continuous	____	____
Controllability ***Could/can you stop thinking about killing yourself or wanting to die if you want to?*** (1) Easily able to control thoughts (2) Can control thoughts with little difficulty (3) Can control thoughts with some difficulty (4) Can control thoughts with a lot of difficulty (5) Unable to control thoughts (0) Does not attempt to control thoughts	____	____
Deterrents ***Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of committing suicide?*** (1) Deterrents definitely stopped you from attempting suicide (2) Deterrents probably stopped you (3) Uncertain that deterrents stopped you (4) Deterrents most likely did not stop you (5) Deterrents definitely did not stop you (0) Does not apply	____	____
Reasons for Ideation ***What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling (in other words you couldn't go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both?*** (1) Completely to get attention, revenge or a reaction from others (2) Mostly to get attention, revenge or a reaction from others (3) Equally to get attention, revenge or a reaction from others and to end/stop the pain (4) Mostly to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (5) Completely to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (0) Does not apply	____	____

SUICIDAL BEHAVIOR *(Check all that apply, so long as these are separate events; must ask about all types)*	**Lifetime**	**Past 3 months**
Actual Attempt: ***Have you made a suicide attempt?*** ***Have you done anything to harm yourself?*** ***Have you done anything dangerous where you could have died?*** ***What did you do?*** ***Or did you do it purely for other reasons / without ANY intention of killing yourself (like to relieve stress, feel better, get sympathy, or get something else to happen)?*** (Self-Injurious Behavior without suicidal intent) If yes, describe:	**Yes** ☐ **No** ☐ Total # of Attempts _____	**Yes** ☐ **No** ☐ Total # of Attempts _____
Have you engaged in Non-Suicidal Self-Injurious Behavior?	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
Has there been a time when you started to do something to end your life but someone or something stopped you before you actually did anything? If yes, describe:	**Yes** ☐ **No** ☐ Total # of interrupted _____	**Yes** ☐ **No** ☐ Total # of interrupted _____
Has there been a time when you started to do something to try to end your life but you stopped yourself before you actually did anything? If yes, describe:	**Yes** ☐ **No** ☐ Total # of aborted or self-interrupted _____	**Yes** ☐ **No** ☐ Total # of aborted or self-interrupted _____
Have you taken any steps towards making a suicide attempt or preparing to kill yourself (such as collecting pills, getting a gun, giving valuables away or writing a suicide note)? If yes, describe:	**Yes** ☐ **No** ☐ Total # of preparatory acts _____	**Yes** ☐ **No** ☐ Total # of preparatory acts _____

	Most Recent Attempt Date:	Most Lethal Attempt Date:	Initial/First Attempt Date:
Actual Lethality/Medical Damage: 0. No physical damage or very minor physical damage (e.g., surface scratches). 1. Minor physical damage (e.g., lethargic speech; first-degree burns; mild bleeding; sprains). 2. Moderate physical damage; medical attention needed (e.g., conscious but sleepy, somewhat responsive; second-degree burns; bleeding of major vessel). 3. Moderately severe physical damage; *medical* hospitalization and likely intensive care required (e.g., comatose with reflexes intact; third-degree burns less than 20% of body; extensive blood loss but can recover; major fractures). 4. Severe physical damage; *medical* hospitalization with intensive care required (e.g., comatose without reflexes; third-degree burns over 20% of body; extensive blood loss with unstable vital signs; major damage to a vital area). 5. Death	*Enter Code* _____	*Enter Code* _____	*Enter Code* _____
Potential Lethality: Only Answer if Actual Lethality=0 Likely lethality of actual attempt if no medical damage (the following examples, while having no actual medical damage, had potential for very serious lethality: put gun in mouth and pulled the trigger but gun fails to fire so no medical damage; laying on train tracks with oncoming train but pulled away before run over). 0 = Behavior not likely to result in injury 1 = Behavior likely to result in injury but not likely to cause death 2 = Behavior likely to result in death despite available medical care	*Enter Code* _____	*Enter Code* _____	*Enter Code* _____

COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)

Posner, Brent, Lucas, Gould, Stanley, Brown, Fisher, Zelazny, Burke, Oquendo, & Mann

RISK ASSESSMENT VERSION

Instructions: Check all risk and protective factors that apply. To be completed following the patient interview, review of medical record(s) and/or consultation with family members and/or other professionals.

Suicidal and Self-Injury Behavior (Past week)		**Clinical Status (Recent)**	
☐	Actual suicide attempt ☐ Lifetime	☐	Hopelessness
☐	Interrupted attempt ☐ Lifetime	☐	Helplessness*
☐	Aborted attempt ☐ Lifetime	☐	Feeling Trapped*
☐	Other preparatory acts to kill self ☐ Lifetime	☐	Major depressive episode
☐	Self-injury behavior w/o suicide intent ☐ Lifetime	☐	Mixed affective episode
Suicide Ideation (Most Severe in Past Week)		☐	Command hallucinations to hurt self
☐	Wish to be dead	☐	Highly impulsive behavior
☐	Suicidal thoughts	☐	Substance abuse or dependence
☐	Suicidal thoughts with method (but without specific plan or intent to act)	☐	Agitation or severe anxiety
☐	Suicidal intent (without specific plan)	☐	Perceived burden on family or others
☐	Suicidal intent with specific plan	☐	Chronic physical pain or other acute medical problem (AIDS, COPD, cancer, etc.)
Activating Events (Recent)		☐	Homicidal ideation
☐	Recent loss or other significant negative event	☐	Aggressive behavior towards others
	Describe:	☐	Method for suicide available (gun, pills, etc.)
		☐	Refuses or feels unable to agree to safety plan
☐	Pending incarceration or homelessness	☐	Sexual abuse (lifetime)
☐	Current or pending isolation or feeling alone	☐	Family history of suicide (lifetime)
Treatment History		**Protective Factors (Recent)**	
☐	Previous psychiatric diagnoses and treatments	☐	Identifies reasons for living
☐	Hopeless or dissatisfied with treatment	☐	Responsibility to family or others; living with family
☐	Noncompliant with treatment	☐	Supportive social network or family
☐	Not receiving treatment	☐	Fear of death or dying due to pain and suffering
Other Risk Factors		☐	Belief that suicide is immoral, high spirituality
☐		☐	Engaged in work or school
		☐	Engaged with Phone Worker *
		Other Protective Factors	
		☐	

Describe any suicidal, self-injury or aggressive behavior (include dates):

Part 1

Instructions: Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check one or more of the boxes to the right to indicate that: (a) it happened to you personally; (b) you witnessed it happen to someone else; (c) you learned about it happening to a close family member or close friend; (d) you were exposed to it as part of your job (for example, paramedic, police, military, or other first responder); (e) you're not sure if it fits; or (f) it doesn't apply to you.

Be sure to consider your entire life (growing up as well as adulthood) as you go through the list of events.

Event	Happened to me	Witnessed it	Learned about it	Part of my job	Not sure	Doesn't apply
1. Natural disaster (for example, flood, hurricane, tornado, earthquake)						
2. Fire or explosion						
3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash)						
4. Serious accident at work, home, or during recreational activity						
5. Exposure to toxic substance (for example, dangerous chemicals, radiation)						
6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)						
7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)						
8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)						
9. Other unwanted or uncomfortable sexual experience						
10. Combat or exposure to a war-zone (in the military or as a civilian)						
11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)						
12. Life-threatening illness or injury						
13. Severe human suffering						
14. Sudden violent death (for example, homicide, suicide)						
15. Sudden accidental death						
16. Serious injury, harm, or death you caused to someone else						
17. Any other very stressful event or experience						

Part 2

A. If you checked anything for #17 in PART 1, briefly identify the event you were thinking of:

B. If you have experienced more than one of the events in PART 1, think about the event you consider the worst event, which for this questionnaire means the event that currently bothers you the most. If you have experienced only one of the events in PART 1, use that one as the worst event. Please answer the following questions about the worst event (check all options that apply):

Briefly identify the worst event (if you feel comfortable doing so):

How long ago did it happen? _____ (please estimate if you are not sure)

How did you experience it?

- ☐ It happened to me directly
- ☐ I witnessed it
- ☐ I learned about it happening to a close family member or close friend
- ☐ I was repeatedly exposed to details about it as part of my job (for example, paramedic, police, military, or other first responder)
- ☐ Other, please describe

Was someone's life in danger?

- ☐ Yes, my life
- ☐ Yes, someone else's life
- ☐ No

Was someone seriously injured or killed?

- ☐ Yes, I was seriously injured
- ☐ Yes, someone else was seriously injured or killed
- ☐ No

Did it involve sexual violence? ☐ **Yes** ☐ **No**

If the event involved the death of a close family member or close friend, was it due to some kind of accident or violence, or was it due to natural causes?

- ☐ Accident or violence
- ☐ Natural causes
- ☐ Not applicable (the event did not involve the death of a close family member or close friend)

How many times altogether have you experienced a similar event as stressful or nearly as stressful as the worst event?

- ☐ Just once
- ☐ More than once (please specify or estimate the total number of times you have had this experience _____)

Part 3

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Keeping your worst event in mind, please read each problem carefully and then select one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

Your worst event: _____

In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

PCL-5 SCORING WORKSHEET (STAFF USE ONLY)

Cluster	Items	Score
B. Intrusion	1-5	____ / 20
C. Avoidance	6-7	____ / 8
D. Cognition & Mood	8-14	____ / 28
E. Arousal & Reactivity	15-20	____ / 24

TOTAL PCL-5 SCORE: _____ / 80

DSM-5 SYMPTOM CLUSTER CHECK

Cluster	Requirement	Met?
B (Items 1-5)	≥1 symptom rated 2+	☐
C (Items 6-7)	≥1 symptom rated 2+	☐
D (Items 8-14)	≥2 symptoms rated 2+	☐
E (Items 15-20)	≥2 symptoms rated 2+	☐

INTERPRETATION

Score Range	Clinical Interpretation
0-30	Below common PTSD screening cutoff
31-32	Borderline - Clinical judgment recommended
33+	Probable PTSD - Further assessment recommended

CLINICAL ACTION

☐ No further trauma assessment indicated

☐ Discuss trauma-related symptoms during intake

☐ Complete additional PTSD assessment

☐ Refer for trauma-focused treatment

☐ Safety assessment indicated

Southwestern Oklahoma State University
Hilltop Health

INFORMED CONSENT
FOR FACE-TO-FACE AND TELEBEHAVIORAL HEALTH COUNSELING SERVICES

Introduction

Welcome to the Hilltop Health at Southwestern Oklahoma State University (SWOSU). This document provides important information about the counseling services available to you, including your rights and responsibilities as a client. This is a legal document. Please read it carefully before signing. Your counselor will be happy to answer any questions you may have. You may request a copy of this document for your records.

Eligibility

Counseling services are available to students who are currently enrolled at SWOSU. To be eligible, students must be enrolled in at least one (1) credit hour during the semester in which services are received.

SWOSU employees and their dependents may be eligible for a limited number of sessions through off-campus counseling providers. Please contact Human Resources for additional information regarding these services.

Confidentiality

Your participation in counseling is confidential. Information shared during counseling sessions will not be disclosed to individuals or agencies outside of the Counseling Center without your written permission, except under specific circumstances required or permitted by law.

Counselors adhere to the ethical standards of their profession and applicable state and federal laws. In some cases, counselors may consult with other Counseling Center staff to provide the best possible care. In these situations, only the minimum necessary information is shared.

Limits of Confidentiality: Confidential information may be disclosed without your consent under the following circumstances:

- If you present a risk of serious harm to yourself or another person
- If there is suspected abuse or neglect of a minor, elderly person, or vulnerable adult (as required by law)
- If your records are subpoenaed or otherwise required by a valid court order
- If there is a medical emergency requiring immediate intervention
- If disclosure is otherwise required or permitted by law
- If someone referred you to the SWOSU Counseling Center (e.g., physician, instructor, advisor, RA) and they inquire, may we confirm that you did schedule an appointment?

☐ Yes ☐ No ☐ Does Not Apply

Expanded Informed Consent for Care Coordination (BIT Team)

The Counseling Center may collaborate with a multidisciplinary team (e.g., the Behavioral Intervention Team, or BIT) to support student safety, well-being, and success. With your permission, limited information may be shared with appropriate university personnel on a need-to-know basis for the purpose of coordinating care and support.

This may include information such as your engagement in services (e.g., attendance), general concerns related to safety or well-being, and recommendations for support or follow-up. This does not include detailed session content, psychotherapy notes, or specific personal disclosures, except when required by law or in situations involving risk of harm to yourself or others. The purpose of this coordination is to enhance support, promote student safety, and ensure an appropriate and timely response to concerns.

Client Choice (Please select one):

☐ I consent to the limited sharing of information with the Behavioral Intervention Team (BIT) as described above

☐ I do NOT consent to this information sharing, except in situations where disclosure is required by law or necessary to prevent serious harm

Telebehavioral Health (Telehealth) Services

Telehealth services may be offered as part of your care. These services use electronic communication technologies to provide counseling remotely. The Counseling Center uses secure, HIPAA-compliant platforms when available; however, there are inherent risks associated with electronic communication, including potential interruptions, technical failures, or unauthorized access. By participating in telehealth services, you acknowledge:

- You are responsible for ensuring privacy in your environment
- You understand the potential risks and limitations of telehealth
- You have the right to request in-person services when available

Counseling Services and Nature of Counseling

The Counseling Center provides a range of services including initial intake and assessment, individual counseling (brief, solution-focused), crisis intervention, group counseling, psychoeducational programming and workshops, and referrals to community providers when appropriate. Counseling services are designed to be short-term and goal-oriented, with the length and frequency of services determined collaboratively between you and your counselor based on your individual needs, goals, and clinical recommendations.

Counseling is a collaborative and voluntary process intended to help individuals address personal concerns, develop coping strategies, and work toward meaningful change. You may discontinue services at any time and are encouraged to discuss any questions or concerns with your counselor throughout the process. Counseling may involve exploring difficult or emotional topics, which can sometimes result in temporary discomfort. While many individuals benefit from counseling, specific outcomes cannot be guaranteed. The goal of counseling is to support you in developing skills and insight that you can continue to use beyond your time in services. If your needs extend beyond the scope of services offered, your counselor will assist you in connecting with appropriate community resources.

Emergencies

If you are experiencing an emergency during office hours, please notify Counseling Center staff immediately so that you may be seen as soon as possible. For after-hours emergencies, please contact: **SWOSU Campus Police at (580).774.3111, 911 or 988.**

Statement of Professional Disclosure

All counselors at the SWOSU Counseling Center are licensed professionals or supervised trainees working under appropriate supervision in accordance with state law. Clinical staff may include Licensed Professional Counselors (LPC) and Licensed Alcohol and Drug Counselors (LADC). All counselors are licensed by the Oklahoma State Board of Behavioral Health Licensure, which regulates professional standards and practices in the state of Oklahoma.

If you have concerns about your care that cannot be resolved with your counselor, you may contact the licensing board or request to speak with the Director of Counseling Services. The licensing website is https: //www.ok.gov/behavioralhealth/ where you can access the law and regulation, which govern their licenses. Counselors will furnish you with printed materials about the requirements of licensure if you so desire. You may contact (without giving your name) the Professional Counselor Licensing Division at:

State Board of Behavioral Health Licensure (BBHL)
3815 N. Santa Fe, Suite 110
Oklahoma City, OK 73118
Phone: (405). 522.3696
Fax: (405). 522.3691

Records
The Counseling Center maintains electronic records of services provided, which may include intake information, session notes, assessments, and other relevant documentation. These records are stored securely, are kept separate from academic records, and are accessible only to Counseling Center staff. All records are maintained in accordance with applicable state and federal laws and regulations. You may request access to your records as permitted by law.

Attendance Policy / No Show Policy
To ensure timely access to services for all students, you are expected to provide at least 24 hours' notice if you need to cancel or reschedule an appointment. Missing an appointment without notice (a "no-show") may result in the loss of a standing appointment time, and repeated no-shows may impact your ability to continue scheduling appointments at the Counseling Center. Exceptions may be made in cases of illness, emergency, or other extenuating circumstances. (***No Show** is defined as not calling to cancel your appointment or calling to cancel with less than 24 hours' notice.)

Contact Me
To protect your confidentiality, please indicate how we may contact you. Please be aware that an outside party could intercept information exchanged over e-mail.

Okay to Leave a Message	**Please check all that apply**	
Cell Phone: _____	☐ Yes	☐ No
SWOSU E-mail Address: _____	☐ Yes	☐ No
Other: _____	☐ Yes	☐ No

If there are any concerns with the Counseling Center that you cannot discuss with your counselor, please contact the Director of Counseling Services or the Vice President for Student Affairs.

Consent for Services
I certify that I have read, understand, and agree to abide by the information outlined above regarding my eligibility and use of SWOSU Hilltop Health services. I hereby give my consent to authorize the Center for Health and Well-being to evaluate, treat, and/or refer me to others as needed. I have had the opportunity to discuss questions regarding the above information.

Client Signature Date