



INTAKE ASSESSMENTS

James Madison University
Counseling Center

“Bringing home baby...”

- Conceptualized and developed collaboratively “in-house” in late spring and summer of 2009; implemented in fall 2009
- Proactive response to:
 - Increased use of Center services
 - Increased wait time between initial contact and first appointment
 - Overtaxed Emergency/Crisis system
 - Desire to introduce students to an array of treatment modalities
- Important considerations in development:
 - Type and amount of information collected
 - Provided by student via computer form
 - In person/clinician inquiry
 - Sequence of questions
 - Language
 - Location
 - Appointment time

“Learning to fly...”

- Ironing out the details:
 - Based number of Intake Assessments (IA) offered on data gathered previous year
 - Developed criteria to “bump”
 - SI
 - HI
 - Auditory/Visual hallucinations
 - Sexual Assault
- Bumps in the road:
 - Adjusted Informed Consent
 - Learning curve for students/faculty/staff
 - Tweaking form
 - Consistency in disposition decisions

“How to train YOUR dragon...”

- Helpful Hints
 - Hire good people!
 - Flexibility and willingness to adapt/adjust as needed
 - Titanium
 - Develop detailed training for new clinicians/trainees
 - Consider “specialists”
 - Incorporate documentation time for both students and clinicians
 - Minimize text boxes; favor check boxes
 - Consider offering more IAs during “high traffic” weeks/months
 - If using Titanium, create paper copies of intake questions

Client Information Form

James Madison University
Counseling & Student Development Center
Center Forms

Client Information (SDS)

Please read the document you received titled 'Notice of Privacy Practices/Informed Consent.' After reading this document please read and sign the following:

I have read and understand the information from the Initial Assessment informed consent form. I consent to the outlined policies and procedures. I acknowledge that I have received a copy of the CSDC Notice of Privacy Practice/Informed Consent Form

The following constitutes your digital signature to the statement above:

Your JMU JACard #: _____ → First Name: _____ → Last Name: _____

Basic Background Information

Date of Birth: _____

Gender: _____

Race/Ethnicity: _____

Are you an International Student? Yes No

What is your country of origin? _____

Are you a dependent (Does someone claim you as a dependent on his/her tax form)? Yes No

What kind of housing do you currently live in? _____

With whom do you live?

Alone

Spouse, partner, or significant other

Roommate(s)

Children

Parent(s) or guardian(s)

Family Other

Other (please specify): _____

Sexual Orientation: _____

Relationship status: _____

Religious or spiritual preference: _____

To what extent does your religious or spiritual preference play an important role in your life?

Have you ever been enlisted in any branch of the U.S. military (active duty, veteran, national guard or reserves)? Yes No

Did your military experiences include any traumatic or highly stressful experiences which continue to bother you? Yes No

Are you the first generation in your family to attend college? Yes No

Did you transfer from another campus/institution to this school? Yes No

Are you an intercollegiate athlete? Yes No

Current Academic Status: _____

Credits Taken This Semester: _____

What is your current GPA? _____

What is your major? _____

Who is your advisor? _____

Are you currently on academic suspension or probation? Yes No

Were you previously on academic suspension or probation? Yes No

Are you currently employed? Yes No

→ If yes, how many hours per week? _____

Do you have health concerns or conditions? Yes No

→ If yes, please list them here: _____

→ → → → → _____

Are you registered, with the office for disability services on this campus, as having a documented and diagnosed disability? Yes No

If you selected "Yes" for the previous question, please indicate which category of disability you are registered for (check all that apply):

Attention Deficit/Hyperactivity Disorder

Deaf or Hard of Hearing

Learning Disorders

Mobility Impairments

Neurological Disorders

Physical health related Disorders

Psychological Disorder/Conditions

Visual Impairments

Other (please specify): _____

How would you describe your financial situation right now: _____

How would you describe your financial situation while growing up: _____

Client Information Form (cont'd)

Please indicate if and when you had the follow experiences*

Attended counseling for mental health concerns: Yes No

→ If so, when: _____

Taken a prescribed medication for mental health concerns: Yes No

→ If so, when: _____



Experiences ^α	How many times? ^α	When was the last time you experienced this? ^α
Been hospitalized for mental health concerns ^α	<input type="checkbox"/>	<input type="checkbox"/>
Felt the need to reduce your alcohol or drug use ^α	<input type="checkbox"/>	<input type="checkbox"/>
Received treatment for alcohol or drug use ^α	<input type="checkbox"/>	<input type="checkbox"/>
Purposely injured yourself without suicidal intent (e.g. cutting, hitting, burning, hair-pulling, etc.) ^α	<input type="checkbox"/>	<input type="checkbox"/>
Seriously considered attempting suicide ^α	<input type="checkbox"/>	<input type="checkbox"/>
Made a suicidal attempt ^α	<input type="checkbox"/>	<input type="checkbox"/>
Considered seriously injuring another person ^α	<input type="checkbox"/>	<input type="checkbox"/>
Intentionally caused serious injury to another person ^α	<input type="checkbox"/>	<input type="checkbox"/>
Had unwanted sexual contact(s) or experience(s) ^α	<input type="checkbox"/>	<input type="checkbox"/>
Experienced harassing, controlling, and/or abusive behavior from another person (e.g. friend, family member, partner, or authority figure) ^α	<input type="checkbox"/>	<input type="checkbox"/>
Experienced a traumatic event that caused you to feel intense fear, helplessness, or horror ^α	<input type="checkbox"/>	<input type="checkbox"/>

On average, how many days do you drink alcohol each week? _____

When drinking alcohol how many drinks do you typically have? _____

Think back over the last two weeks. How many times have you had five or more drinks* in a row (for males) OR four or more drinks* in a row (for females)? (A drink is a bottle of beer, a glass of wine, a wine cooler, a shot glass of liquor, or a mixed drink.) _____

Think back over the last two weeks. How many times have you smoked marijuana? _____

Do you use recreational drugs, or drugs not prescribed for you? Yes No

Do you currently have concerns about your alcohol and/or drug use? Yes No

Have you ever had concerns about your alcohol and/or drug use? Yes No

Current Issues*

Please identify your current issues/concerns

I am feeling sad or depressed

I am feeling anxious

I am concerned about my eating patterns or level of exercise, OR I have concerns about my weight or body image

I am struggling with anger

I am experiencing discrimination

I am struggling with my sexual identity

I am struggling with a relationship difficulty

I am struggling with academic-related concerns

I believe my life is in danger

I must make a major life decision (e.g. terminate pregnancy, leave school) within days

I would like to receive counseling (group, couples, or individual)

I would like to receive medical and counseling (group/couples/individual)

I would like to receive medication only

I would like to be referred to a therapist off campus

I have judicial or legal concerns

I have experienced the death of a loved one within the past four weeks

I have intentionally injured myself in the past month

I am currently considering suicide

I am currently considering seriously harming someone else

I am hearing voices or seeing things that others do not hear or see

I have an urgent need to speak with a counselor about sexual assault I experienced

Briefly describe your present concern in the space allotted: |

What would you like to be different as a result of coming to the counseling center?

Initial Assessment Education

Check all that apply:

- Confidentiality reviewed
- Professional disclosure supervision (if applicable) reviewed
- Brief therapy model reviewed
- Possibility of off-campus referral based on presenting concerns reviewed

Brief Demographics:

Date of Birth:

N/A

- Currently taking prescribed or over-the-counter medications

Med name & dosage

Student's sources of support

Family History

- Psychological problems in family
- Alcohol or drug problems in family
- History of suicide/attempted suicide in family

Document family psychological, substance, or suicide issues here

Risk Assessment:

Have you intentionally injured yourself in the past 6 months? (if yes, document in text box)

- Yes No

Ever attempted suicide in the past? (if yes, document in text box)

- Yes No

Have you had suicidal thoughts in the past six months? (if yes, document in text box)

- Yes No

If student has had recent suicidal ideation ask the following:

How likely is it that you will try to kill yourself?

Have you thought about when or how you might kill yourself?

- Yes No

Details about suicidality/self-injury:

Have you had thoughts of killing someone in the past six months? (if yes, document in text box)

- Yes No

If yes to homicidality, ask the following:

How likely is it that you will try to kill someone else?

Have you thought about when or how you might harm/kill someone else?

- Yes No

Have you ever attempted to harm someone in the past?

- Yes No

Details about threat of harm to others/homicidality:

If yes to EITHER suicidality OR homicidality, ask the following:

Do you have access to the means to harm yourself or someone else?

- Yes No

Mitigating Factors:

Mental Status Exam

Appearance

- Well dressed
- Well groomed
- Poor hygiene
- Disheveled
- Inappropriate dress

Eye Contact

- Good eye contact
- Averted eye contact
- Darting eye contact

Speech

- Normal rate/volume/tone
- Loud
- Soft
- Slowed
- Slurred
- Monotone
- Pressured

Affect

- Congruent
- Full reactive
- Flat
- Restricted
- Labile
- Expansive
- Non-congruent

Perceptual Disturbances

- None
- Visual hallucinations
- Auditory hallucinations
- Other hallucinations
- Illusions
- Cannot be determined

Judgment

- Intact
- Fair
- Poor
- None
- Cannot be determined

Estimated Level of Intelligence

- Above average
- Average
- Below average
- Cannot be determined

Additional Mental Status details:

Attitude

- Cooperative with interview
- Uncooperative with interview
- Guarded
- Agitated

Motor Activity

- Normal MA
- Psychomotor agitated
- Psychomotor retardation
- Tremor
- Impulsive

Mood

- Euthymic
- Depressed
- Dysphoric
- Elated
- Elevated

Thought Process

- Linear/logical
- Goal Directed
- Impoverished
- Tangential
- Circumstantial
- Blocking
- Ruminating
- Perseverating
- Flight of Ideas
- Loose Associations

Insight

- Intact
- Fair
- Poor
- None
- Cannot be determined

Memory

- Normal
- Impaired immediate
- Impaired recent
- Impaired remote
- Cannot be determined

Current Issue(s):

Presenting Problem (symptoms, duration, impact)

Appropriateness of Client for CSDC Services - Check All That Apply

- Non-severity of prior treatment
- Positive use of prior therapy
- High motivation for change
- Desire for symptom relief
- Presence of a situational problem
- Ability to experience feelings, be introspective, and monitor self
- Ability to develop trust, openness, and relationships with therapist and others

Additional details regarding appropriateness for services

CSDC Clinical Referral

- Scheduled 30 minute follow-up IA appointment with this IA clinician

Client Disposition

- CC Ref - Animal Therapy
- CC Ref - Anxiety Tx Program
- CC Ref - Anxiety Online Tx Program
- CC Ref - Biofeedback
- CC Ref - Case Manager
- CC Ref - Expressive Arts Room
- CC Ref - Group Therapy
- CC Ref - Mindfulness Group
- CC Ref - Psychiatric Intake
- CC Ref - Relaxation Room
- CC Ref - Resiliency Tx Program
- CC Ref - Resiliency Online Tx Program
- CC Ref - Skills Group (Feel Better Fast, Sleep Soundly, etc.)
- JMU Ref - Academic Support (CAP, LSI, Advisor, Learning Center, FYI)
- JMU Ref - Health Center
- JMU Ref - HOPE Team
- JMU Ref - Mental Health Withdrawal
- JMU Ref - Office of Dean of Students
- JMU Ref - Office of Disability Services
- JMU Ref - Other Dept (i.e., CMSS, UREC, etc.)
- JMU Ref - Nutritionist
- JMU Ref - Substance Abuse Prevention (BASICS, High Expectations)
- Off Campus Ref - Community Counseling Provider
- Off Campus Ref - Community Psychiatric Services
- Off Campus Ref - Evaluation at hospital; client refused
- Off Campus Ref - Evaluation at hospital; discharged
- Off Campus Ref - Evaluation at hospital; inpatient
- Off Campus Ref - Partial Hospitalization Program
- Off Campus Ref - Substance Abuse Services
- Other (referral not listed, client will contact to reschedule, etc)
- Reassigned Counselor
- Recommended Medical Consultation
- Recommended Psychological Assessment
- Scheduled Indiv Appt
- Termination (Remember to uncheck 'Active')

Declined Recommendations

- CC Ref - Animal Therapy
- CC Ref - Anxiety Tx Program
- CC Ref - Anxiety Online Tx Program
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- Off Campus Ref - Community Psychiatric Services
- Off Campus Ref - Partial Hospitalization Program
- Off Campus Ref - Substance Abuse Services
- Recommended Medical Consultation
- Recommended Psychological Assessment

- Reviewed access to emergency care
- Reviewed video recording procedures & client agrees to video recording
- Student agrees with plan

Disposition Notes

STUDENT SUCCESS CENTER
COUNSELING CENTER
JAMES MADISON UNIVERSITY



Questions?

Thank you!