

**Counseling and Psychological Services (CAPS)
The College of New Jersey**

Our Professional Disclosure & Services Contract

Welcome to CAPS. This document contains important information about our professional services and business policies. Please read it carefully and jot down any questions you might have so that you can discuss them with your therapist. When you **sign this document** (see next page) it will represent an agreement between us.

REGARDING OUR PROFESSIONAL SERVICES

Counseling and other psychological/psychiatric services are not easily described in general statements. It varies depending on the personalities of the therapist and student, and the particular issues or concerns you bring forward. There are many different methods we may use to deal with the issues or concerns that you hope to address. Receiving services at CAPS is not like a medical doctor visit. Instead, it calls for a very active effort on your part. Your counseling will realize the greatest success if you work on things discussed not only during sessions but also outside of your time at CAPS.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who undertake it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress; however, there are no guarantees of what you will experience.

The first session or two will involve an evaluation of your needs; this process is referred to as an “intake evaluation” and is designed to provide you some first impressions regarding what course of action might be most beneficial given the issues and concerns you present. You should evaluate this information along with your own opinions of whether you feel comfortable working with CAPS to determine the next course of action. CAPS utilizes a brief model of service; as such, we carefully evaluate all relevant information regarding resources, sources of support, and previous responses to therapy to identify a treatment plan that best serves your needs. While the options available to us are many, we may suggest time-limited psychotherapy at CAPS, group counseling at CAPS, referral to a new or previously known community based provider, arranging a psychiatric medication evaluation, or consultation with another TCNJ departmental office. If you have questions about any of our procedures, we encourage you to discuss them whenever they arise.

INITIATING THE INTAKE EVALUATION

After completion of the attached Student Request for Services Form (RFS) we ask that you submit it to our front office located in 107 Eickhoff Hall (shared reception with Student Health Services). At that time, you will be provided an estimate for scheduling of the intake evaluation and perhaps asked to separately schedule a 20 minute appointment to complete a computer based assessment. While we aspire to schedule the intake assessment within a few days of your request, during busier times of the year your wait will likely be longer. You can expect that the intake evaluation and any subsequent appointments will take 45 to 50 minutes.

ON-GOING MEETINGS AND SCHEDULING

We will try our best to accommodate your scheduling needs so it is important to thoroughly indicate your availability on the RFS (Request for Services) form. On-going appointments may vary from week-to-week though we aim for consistency. Your therapist will discuss this matter in greater detail during the intake evaluation. Please note that our services are free. However, if you do not appear for a scheduled appointment or fail to cancel within 12 hours of a scheduled appointment, you will incur a \$10 charge. It is important that you understand that we have a limited number of therapist hours to meet the demands of the TCNJ campus. We appreciate in advance your consideration of others. To cancel and reschedule an appointment you may email us at xcaps@tcnj.edu or contact our front office at (609) 771-2247. We reserve the right to terminate this agreement if you fail to provide adequate notification of cancellation for two consecutive or three non-consecutive sessions during any academic semester.

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CONFIDENTIALITY

In general, the privacy of all communications between a patient and a therapist is protected by law, and we can only release information about our work to others with your written permission. But there are a few exceptions. There are some situations in which we are legally obligated to take action to protect others from harm, even if we have to reveal some information about your treatment. For example, if we believe that you are threatening serious bodily harm to another, we are required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization. If you threaten to harm yourself or we learn of current abuse involving a minor child or vulnerable adult, we may be obligated to break confidentiality so we can help provide protection.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that you discuss any questions or concerns that you may have with your therapist.

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MINORS

If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records (there are a few exceptions). It is our policy to request an agreement from parents that they will give up access to your records. If they agree, we will provide them only with general information about our work together, unless we feel there is a high risk that you will harm yourself or someone else. In this case, we will notify them of our concern. If requested, we are obligated to provide them with a summary of your treatment when it is complete. Before giving them any information, we will discuss the matter with you, if possible, and do our best to handle any objections you may have with what we prepared to discuss.

USE OF INTERNS

CAPS provides advanced training to area students pursuing careers in counseling and psychotherapy. Our vibrant program utilizes pre-master's and pre-doctoral students to provide a host of services conducted at our center. All of our interns are carefully screened for appropriateness to serve the TCNJ student population; to this end, they abide by the same expectations regarding privacy, confidentiality, and professionalism as do our professionally trained staff. Please be aware that each intern is closely supervised by a professional staff member and that you will receive high quality care. As part of our training program, we often tape record (audio and/or video) therapy sessions. Your written permission is required, and will be requested before any taping occurs. Tapes are used only for consultation with other counselors. They are kept in secure locations and are erased at the conclusion of each semester, if not before.

ABOUT OUR STAFF

Service is provided by professionally trained staff consisting of:

- **Dr. Hue-Sun Ahn**, *Licensed Psychologist*
- **Dr. Marc Celentana**, *Licensed Psychologist, Director*
- **Ms. Kathy Ertel**, *Counselor*
- **Ms. Carol Evangelisto**, *Licensed Professional Counselor*
- **Ms. Ann Fallon**, *Clinician Educator, School of Nursing*
- **Dr. Larry Gage**, *Licensed Psychologist, Associate Director*
- **Dr. Sarala Mundassery**, *Consulting Psychiatrist*

ABOUT YOU AND YOUR THERAPIST

It is important to keep in mind that you and your therapist have a *professional* relationship, rather than a *personal* one. If you believe that you and your counselor are not a good match, please let us know. We will make every effort to resolve the issue to your satisfaction.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

X _____
Student's (or parent/guardian's) signature

X _____
Printed Name

X _____
Date

II. Demographic and General Background Information

Who referred you to CAPS? (check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Self
<input type="checkbox"/> Parents/ Family Member
<input type="checkbox"/> Partner/Spouse
<input type="checkbox"/> Coach
<input type="checkbox"/> Academic Advisor
<input type="checkbox"/> EOF Advisor

<input type="checkbox"/> Faculty: _____
<input type="checkbox"/> Staff: _____ | <input type="checkbox"/> Friend(s)
<input type="checkbox"/> Student Health Services
<input type="checkbox"/> Other Medical Professional
<input type="checkbox"/> TCNJ Community Standards
<input type="checkbox"/> Residential Ed / Housing
<input type="checkbox"/> Other _____ |
|--|---|

Do you give permission so that we can inform them that you came to CAPS? Yes No

Ethnic/Cultural/Racial Identity:

-
- African-American / Black / African
-
-
- American Indian or Alaskan Native
-
-
- Arab American / Arab / Persian
-
-
- Asian American / Asian
-
-
- East Indian
-
-
- European American / White / Caucasian
-
-
- Hispanic / Latino / Latina
-
-
- Native Hawaiian / Pacific Islander
-
-
- Multi-racial/ethnic
-
-
- Prefer not to answer
-
-
- Other (please specify): _____

Date of Birth:

____ / ____ / ____

Age:

Gender:

Female Male

Are you an International Student?

Yes No

If yes, country of origin:

Are you an Athlete?

Yes No

If yes, what sport(s):

Do you have a car at TCNJ?

Yes No

Sometimes

Are you in ROTC?

Yes No

Have you ever served in a branch of the US Military?

Yes No

Did your service include a combat tour of duty?

Yes No

Have you ever been diagnosed with a disability?

(check all that apply)

-
- Attention Deficit/ Hyperactivity Disorder
-
-
- Neurological Disorder
-
-
- Deaf or Hard of Hearing
-
-
- Physical/ Health Related Disorder
-
-
- Learning Disability/ Disorder
-
-
- Psychological Disorder/ Condition
-
-
- Mobility Impairment
-
-
- Visual Impairment
-
-
- Speech Impairment
-
-
- Other _____

Are you registered with the Office of Differing Abilities at TCNJ?

Yes No

Have you had *previous* counseling or psychotherapy?

Yes No

Where/With Whom?

When?

Why?

Are you *presently* receiving counseling from some person/agency other than TCNJ CAPS?

Yes No

Where/With Whom?

What is (are) the main reason(s) for your request for an evaluation? (Check all that apply.)

- | | |
|---|---|
| <input type="checkbox"/> Personal / Psychological Concerns
<input type="checkbox"/> Career/Vocational Counseling
<input type="checkbox"/> Evaluation for return to campus
<input type="checkbox"/> One- or Two-session problem-solving
<input type="checkbox"/> Group Counseling (select) | <input type="checkbox"/> Academic Performance or Concerns
<input type="checkbox"/> Alcohol / Drug Concerns
<input type="checkbox"/> Withdrawal from TCNJ
<input type="checkbox"/> Other: _____
<input type="checkbox"/> Anxiety Management <input type="checkbox"/> Family Issues <input type="checkbox"/> Food and Mood <input type="checkbox"/> Grief & Loss <input type="checkbox"/> Race & Identity |
|---|---|

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Are you currently under the care of a medical doctor?

Yes No

If yes, name of Physician: _____

Name of Physician's Practice: _____

Have you had a physical exam in the last year?

Yes No If no, when? _____

Do you have any allergies?

No, I have no known allergies
 Yes, I have the following allergies: _____

Please list any medical conditions or health problems
(e.g., chronic pain, headaches, diabetes)

Please list any surgeries and hospitalizations

When For What Medical/Mental Health Condition?

Please list all *current* medications

including prescription meds (psychiatric & other), non-prescription meds, birth control pills, vitamins, herbs and supplements

no medications are taken currently

Medication Dosage Date Started For What Condition?

Please list all medications you have taken *in the past 2 years if not listed above*

including prescription meds (psychiatric & other), non-prescription meds, birth control pills, vitamins, herbs and supplements

I have not taken any medication(s) in the past two years

Medication Date Started Date Stopped For What Condition?

What is your Legal History?: None Are you on probation currently? Yes No

Have you been arrested? Yes No If so, for what? _____

Have you been convicted of DWI? Yes No If so, how many? _____

What **current** legal charges do you have? _____

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III. Psychosocial History

<p>Academic Status:</p> <input type="checkbox"/> Freshman / First-year <input type="checkbox"/> Sophomore <input type="checkbox"/> Junior <input type="checkbox"/> Senior <input type="checkbox"/> Graduate student <input type="checkbox"/> Other (please specify): _____	<p>School(s) of Major(s)?</p> <input type="checkbox"/> Arts and Communication <input type="checkbox"/> Business <input type="checkbox"/> Culture and Society <input type="checkbox"/> Education <input type="checkbox"/> Engineering <input type="checkbox"/> Nursing, Health, & Exer. Sci. <input type="checkbox"/> Science	<p>Major: _____</p> <p>Major: _____</p> <p>Minor: _____</p> <p>Overall GPA: _____</p> <p style="text-align: right;">Credits this semester: _____</p>	
<p>Did you transfer to TCNJ?</p> <p style="text-align: center;"><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="text-align: center;">From?</p> <p style="text-align: center;">_____</p>	<p>Are you employed?</p> <p style="text-align: center;"><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="text-align: center;">Where?</p> <p style="text-align: center;">_____</p>	<p>Number of hours employed per week?</p> <input type="checkbox"/> 1-5 <input type="checkbox"/> 6-10 <input type="checkbox"/> 11-15 <input type="checkbox"/> 16-20 <input type="checkbox"/> 20-40 <input type="checkbox"/> Over 40	<p>Are you the first in your family to attend college?</p> <p style="text-align: center;"><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Class Attendance:</p> <input type="checkbox"/> Good: I attend most of my classes <input type="checkbox"/> Fair: I don't attend class sometimes <input type="checkbox"/> Poor: I frequently miss class <input type="checkbox"/> I have stopped attending classes	<p>Religious or Spiritual preference:</p> <input type="checkbox"/> Agnostic <input type="checkbox"/> Atheist <input type="checkbox"/> Buddhist <input type="checkbox"/> Confucian <input type="checkbox"/> Christian <input type="checkbox"/> Hindu <input type="checkbox"/> Jewish <input type="checkbox"/> Muslim <input type="checkbox"/> No preference <input type="checkbox"/> Prefer not to answer <input type="checkbox"/> Other: _____	<p>To what extent does your religious or spiritual preference play an important role in your life?</p> <input type="checkbox"/> Very Important <input type="checkbox"/> Important <input type="checkbox"/> Neutral <input type="checkbox"/> Unimportant <input type="checkbox"/> Very Unimportant	
<p>Please indicate your level of involvement in co-curricular activities (e.g., sports, clubs, student government)</p> <input type="checkbox"/> I do not participate/None <input type="checkbox"/> Occasional participation <input type="checkbox"/> One regularly attended activity <input type="checkbox"/> Two regularly attended activities <input type="checkbox"/> Three or more regularly attended activities		<p>Please tell us who currently is a member of your social support system (please check all that apply):</p> <input type="checkbox"/> Roommate(s) <input type="checkbox"/> Classmate(s) <input type="checkbox"/> Boyfriend/Girlfriend <input type="checkbox"/> Parents/Family <input type="checkbox"/> Students from TCNJ clubs/organizations <input type="checkbox"/> Church <input type="checkbox"/> Other Person(s) <input type="checkbox"/> I don't have a social support system currently	
<p>Involvements (Please check all that apply):</p> <input type="checkbox"/> Community volunteer <input type="checkbox"/> Fraternity or sorority <input type="checkbox"/> Intramural athletics <input type="checkbox"/> Club sports <input type="checkbox"/> Musical groups <input type="checkbox"/> Peer education <input type="checkbox"/> Student government (SGA, SFB) <input type="checkbox"/> Religious organizations <input type="checkbox"/> Community Advisor (CA) <input type="checkbox"/> Other _____		<p>How much do you agree with the following statement: "I get the emotional help and support I desire from my social network."</p> <input type="checkbox"/> Strongly Agree <input type="checkbox"/> Agree <input type="checkbox"/> Somewhat Agree <input type="checkbox"/> Neutral <input type="checkbox"/> Somewhat disagree <input type="checkbox"/> Disagree <input type="checkbox"/> Strongly Disagree	

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<p>What is your relationship status?</p> <input type="checkbox"/> Single <input type="checkbox"/> Dating <input type="checkbox"/> Serious Dating/ Committed Relationship <input type="checkbox"/> Engaged <input type="checkbox"/> Married/ Partnered <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Other _____ <input type="checkbox"/> Decline to Respond	<p>Sexual Orientation:</p> <input type="checkbox"/> Heterosexual <input type="checkbox"/> Gay <input type="checkbox"/> Lesbian <input type="checkbox"/> Bisexual <input type="checkbox"/> Questioning <input type="checkbox"/> Other: _____ <input type="checkbox"/> Decline to Respond	<p>With whom do you live? (check all that apply)</p> <input type="checkbox"/> Alone <input type="checkbox"/> Spouse, partner, or significant other <input type="checkbox"/> Roommate(s) <input type="checkbox"/> Children <input type="checkbox"/> Parent(s) or guardian(s) <input type="checkbox"/> Other Family <input type="checkbox"/> Other (please specify): _____ _____	<p>What kind of housing do you currently have?</p> <input type="checkbox"/> On-campus residence Building: _____ Room: _____ <input type="checkbox"/> Off-campus apartment/House <input type="checkbox"/> Off-campus fraternity/sorority <input type="checkbox"/> I live at home with my parents <input type="checkbox"/> Other _____
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List family members (include parents, siblings and spouse/children, if applicable):

Name	Relationship	Age	Occupation or Grade in School

Parents' Status (check all that apply):

- Mother** Married Not married Separated Divorced Remarried Widowed Deceased**
- Father** Married Not married Separated Divorced Remarried Widowed Deceased**

** Date(s) of death(s), if applicable:

<p>Does your family have a history of: (check all that apply)</p> <input type="checkbox"/> None of these <input type="checkbox"/> Counseling <input type="checkbox"/> Psychiatric Hospitalization <input type="checkbox"/> Alcoholism <input type="checkbox"/> Drug Use <input type="checkbox"/> Abuse <input type="checkbox"/> Depression <input type="checkbox"/> Eating Disorders <input type="checkbox"/> Poor Communication <input type="checkbox"/> Prison <input type="checkbox"/> Other _____	<p>Please check any past, present, or impending problems in your family: (check all that apply)</p> <input type="checkbox"/> Deaths <input type="checkbox"/> Divorce <input type="checkbox"/> Frequent Relocations <input type="checkbox"/> Debilitating Injuries/ Disabilities <input type="checkbox"/> Serious Illness <input type="checkbox"/> Psychiatric Disorder/Mental Illness <input type="checkbox"/> Physical/ Sexual Abuse <input type="checkbox"/> Domestic Violence <input type="checkbox"/> Financial Crisis/ Unemployment <input type="checkbox"/> Legal Problems <input type="checkbox"/> Attempted/ Completed Suicide <input type="checkbox"/> Other _____	<p>How was your financial situation <u>growing up</u>?</p> <input type="checkbox"/> Always stressful <input type="checkbox"/> Often stressful <input type="checkbox"/> Sometimes stressful <input type="checkbox"/> Rarely stressful <input type="checkbox"/> Never stressful
		<p>How is your financial situation <u>right now</u>?</p> <input type="checkbox"/> Always stressful <input type="checkbox"/> Often stressful <input type="checkbox"/> Sometimes stressful <input type="checkbox"/> Rarely stressful <input type="checkbox"/> Never stressful
<p>▶▶ Continue to next page ▶▶</p>		

IV. Clinical Issues

Are you covered by a private health insurance plan?

Yes No

If yes, check all that apply:

- Aetna
- Amerihealth
- CIGNA
- Horizon Blue Cross/Blue Shield
- Qualcare
- TCNJ student health insurance (Bollinger)
- United Healthcare
- Other: _____

Think back over the last two weeks. How many times have you had:

For males: five or more drinks in a row?
For females: four or more drinks in a row?

<input type="checkbox"/> None <input type="checkbox"/> Once <input type="checkbox"/> Twice	<input type="checkbox"/> 3 to 5 times <input type="checkbox"/> 6 to 9 times <input type="checkbox"/> 10 or more times
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Have you ever blacked out from drinking too much alcohol?

Yes No

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Please indicate (X) if / when you have had the following experiences: <i>Check one per row →</i>	Never	Prior to college	Since starting college	Both – Prior to and since starting college
Attended counseling for mental health concerns				
Taken a prescription medicine for mental health concerns				
Been hospitalized for mental health concerns				
Felt the need to reduce your alcohol or drug use				
Received treatment for alcohol or drug use				
Received treatment for eating / body image concerns				
Purposely injured yourself without suicidal intent (e.g., cutting, hitting, burning, hair pulling)				
Seriously considered attempting suicide				
Made a suicide attempt				
Seriously considered injuring another person				
Intentionally injured another person				
Had unwanted sexual contact or experiences				
Experienced harassing, controlling, and/or abusive behavior from another person				
Experienced, witnessed, or learned of a traumatic event				

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Pre-Intake Outcome Rating Scale

Name _____

Date _____

Looking back over the last week, including today, help us understand how you have been feeling by rating how well you have been doing in the following areas of your life, **where marks (---X---) to the left represent low levels and marks to the right indicate high levels.**

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Not Well

Very Well

Overall:
(General sense of well-being)

-----|

Individually:
(Personal well-being)

-----|

Interpersonally:
(Family, close relationships)

-----|

Socially:
(Work, school, friendships)

-----|

In the past week, to what degree have you been concerned about the following, **where marks (---X---) to the left represent a low degree of concern and marks to the right represent a high degree of concern.**

Thoughts of ending your life:

-----|

Self-injury:

-----|

Thoughts of harming someone else:

-----|

Your own alcohol or substance use:

-----|

LOW degree
of concern

Your eating patterns, weight, and/or physical appearance:

-----|

HIGH degree
of concern

Feeling sad:

-----|

Feeling nervous, anxious, or fearful:

-----|

A significant loss or change:

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Thank you for completing the Student Request for Services Form. Please submit at the CAPS front desk located in Room 107 in Eickhoff Hall. If you have questions of a general nature regarding our services, please contact us at x2247 or caps@tcnj.edu. version 1.1 RFS rev 09/09