Counseling Services - Information Packet
Kenyon College Counseling Services

Student Name

Today’s Date: ____________________________

Birth Date: _______________________________

Preferred pronouns: ______________________

If necessary, may we contact you at any of the locations listed below?

Cell Phone: ___________________________________________   Yes ___   No ___

Campus Email: ________________________________________   Yes ___   No ___

Class: _____________ (First Year, Sophomore, Junior, Senior)

Expected Year of Graduation: __________

Who referred you to Counseling Services?

________________________________________________________________

(e.g., self, Dean, doctor, family member, friend)

If any of your current concerns are causing you to be in crisis, please contact Campus Safety at (740) 427 5555 to connect immediately with a licensed counselor through ProtoCall.
Counseling History

Have you received counseling at the Kenyon Counseling Services before?  Yes ____ No ____
If so, what was the name of the Counselor? _______________________________________
Have you ever received or are currently receiving psychological counseling anywhere? Yes _____
No ____
If so, from whom? ___________________________________________________________________
Where? ___________________________________________________________________________
Approximate Dates: __________________________________________________________________

Counseling Information

Please use the space below to describe the reason you are seeking our services:
_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________

Psychotropic Medication History

Are you taking any medications for the management of depression, anxiety, or other forms of a mental or emotional disorder?  Yes ____ No ____
Please specify if you can:
Name(s) of medication(s), dosage, and name of prescribing physician:
_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________
Substance Use History

Do you use recreational substances? Yes _____  No _____
If yes, list substances:
__________________________________________________________
__________________________________________________________

How often do you use each substance?
__________________________________________________________
__________________________________________________________

Current Symptoms

<table>
<thead>
<tr>
<th>Symptom Checklist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please check all of the following that currently apply. Please indicate past concerns with the written letter “P”.</td>
</tr>
<tr>
<td>□ Distractibility</td>
</tr>
<tr>
<td>□ Hyperactivity</td>
</tr>
<tr>
<td>□ Impulsivity</td>
</tr>
<tr>
<td>□ Boredom</td>
</tr>
<tr>
<td>□ Poor memory/confusion</td>
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<tr>
<td>□ Attention Problems</td>
</tr>
<tr>
<td>□ Anxiety/Worry</td>
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<tr>
<td>□ Panic Attacks</td>
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<tr>
<td>□ Social Discomfort</td>
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<tr>
<td>□ Fear away from home</td>
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<tr>
<td>□ Obsessive thoughts</td>
</tr>
<tr>
<td>□ Compulsive behavior</td>
</tr>
<tr>
<td>□ Seasonal mood changes</td>
</tr>
<tr>
<td>□ Suicide attempts</td>
</tr>
</tbody>
</table>
COX CENTER PROFESSIONAL DISCLOSURE STATEMENT

The purpose of this form is to inform you of the services we provide and who will be providing those services. It also gives you the opportunity to give your consent for counseling. If this form does not satisfactorily answer your questions, do not hesitate to ask your counselor or someone in the office for clarification.

We provide individual, group* and substance abuse counseling. If we are unable to provide the services you need, we will assist you in finding the appropriate resources. For counseling to be most effective it is necessary for you to take an active role in the process and remain open and honest in discussing your concerns. At times this can be difficult, and you may face feelings that make you uncomfortable. This is to be expected and is a normal part of counseling.

Please be aware that if you participate in group counseling you are stating - I understand that if I participate in group counseling each participant has a right to confidentiality and I agree to maintain the confidentiality of information shared by others in the session. I also understand that the Cox Center cannot guarantee that all participants will honor such agreement.

Everything discussed with your counselor will be kept confidential, except in cases of suicidal/homicidal intent, abuse, neglect or abandonment of a child/elderly adult/person with a disability, or when required by law. Except as described above, no information will be released to another campus office or individual without your knowledge and written consent.

Counseling in our office can be short or long term, depending on your needs. In some cases, it may be appropriate to be referred for outside help or treatment. If at any time you decide to discontinue counseling, we encourage you to first discuss this with your counselor. We do not offer services during semester breaks or during summer sessions so sometimes there are gaps in services. If you feel that you would benefit from more continuous care, we can help you find those services.

You may refuse or withdraw from counseling at any time by notifying your counselor. You may be terminated for failure to keep or cancel appointments, violent behavior, threats of violence, or if it is determined that counseling is no longer beneficial. Services may be terminated and appropriate referrals given if students needs are beyond the scope of what this office can provide.

If at any time you feel you need help, do not hesitate to call the office during regular hours. If no one is available in the office, call Campus Safety at 740.427.5555 in order to be connected with ProtoCall.

*There is a current hold on group counseling opportunities during COVID-19 and we will communicate changes for those services when they become available.
CONSENT AND AGREEMENT OF PATIENT

I have read and understand the Cox Center Professional Disclosure Statement, and I agree to voluntarily participate in the counseling process. In case of crisis, I agree to using the numbers provided, in order to ensure the utilization of appropriate means of service. This consent and agreement will apply for so long as I receive services at the Center

_________________________________________________  __________________
Signature of Patient  Date

_________________________________________________
Print Name

If under 18 years old:

_________________________________________________  __________________
Signature of Parent/Guardian  Date

_________________________________________________
Print Name

COX CENTER

Hours of Operation: 8:30 A.M. — 4:30 P.M. Monday-Friday, On-call for emergencies 24/7, 740-427-5555, ask to speak with the ProtoCall.

Confidentiality: The ethical guidelines of the International Association of Counseling Services and Ohio state law guide the services of the Cox Center. The guidelines require that the information you share with your counselor will not be given to individuals who are not on the Cox Center professional staff without your knowledge and written consent, and no record of your use of this service will be placed on your official transcript. You should also know, however, that we are required by law to report situations involving imminent danger to you or someone else, or circumstances involving the neglect or abuse of a child (under 18) or an elderly person. By law, we must also respond to court ordered subpoenas of client records. Unless otherwise required or permitted by law, your counselor will inform you of the need to take such actions before they are initiated.