THE NEW SCHOOL

STUDENT HEALTH SERVICES
Counseling Services
80 5th Avenue, 3rd Floor
New York, NY 10011
Tel: 212.229.1671 option 1
Fax: 212.614.7484

# COUNSELING SERVICES

## CONFIDENTIAL STUDENT INFORMATION

Please complete this form to provide us with information to better understand your concerns. Information is confidential and will not be released without your signed consent except in imminent dangerous situations involving harm to self or other.

**TODAY'S DATE:** _____/_____/_____ (MONTH DAY YEAR)

Please check here _____ if self-referred. If not, referred by _____

If you would like us to contact the person who referred you please let us know. We will not do this without your written permission. ☐ YES ☐ NO

**NAME:** (Last) _____ (First): _____

**NEW SCHOOL ID#:** N:_____ **Date Of Birth:** _____/_____/_____ (MONTH DAY YEAR) Age: _____

**Gender:** (Check all that apply): ☐ Male ☐ Female ☐ Transgender ☐ not sure **Ethnicity:**_____

**Sexual Orientation:** (Check all that apply) **Attracted to:** ☐ Men ☐ Women ☐ Transgender ☐ not sure

**International Student?** ☐ Yes ☐ No **Religious beliefs:**

**Country Of Birth:** **Languages Spoken:**

### CONTACT INFO STUDENT:

**Residence:** ☐ Live alone off campus ☐ Off-Campus w/Roommates ☐ Parents/ Family ☐ Dormitory ☐ Other

**Local Address:** _____ (City State Zip)

**Home Phone:** (_____)_____ **Work:** (_____)_____ **Cellular:**(_____)_____

May we leave a discreet message if necessary to reach you? ☐ Yes ☐ No

**Email Address:** _____

### STUDENT STATUS:

**School:** ☐ Parsons ☐ Lang ☐ NSPE ☐ Social Research ☐ Drama ☐ Jazz ☐ Mannes

**Student Status:** ☐ Undergrad ☐ Grad **Year:** ☐ Fr ☐ So ☐ Jr ☐ Sr ☐ AAS ☐ Masters ☐ Certificate ☐ PhD

**Full-time student?** ☐ Yes ☐ No **Major:** _____ **Expected Date Of Graduation:** _____

**Are You Currently Employed?** ☐ Yes ☐ No **If Yes, Occupation?** _____

Number of hours working: Who supports you financially? _____

### INSURANCE INFO:

Have you paid the Student Health Services fee: ☐ Yes ☐ No Do you have the Student Health Insurance? ☐ Yes ☐ No

If, No what insurance do you have? ID #: Group/Policy #: _____

### OTHER INFO:

Are you being seen at the The New School Medical Services? ☐ Yes ☐ No

Have you been seen at the Counseling Services before? ☐ Yes ☐ No If YES, by whom? _____ When? _____

### PARENT/ GUARDIAN INFO:

**Parent/ Guardian Name:** _____ Relationship:_____ Phone: (_____)_____

**Address:** _____ **City**: _____ **State/ Country:** _____ **Zip:** _____

### EMERGENCY CONTACT INFO:

**Emergency Contact Name:** _____ Relationship: _____ Phone: (____)_____

**Address:** _____ City: _____ State/ Country: _____ Zip: _____

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- ☐ Academic problems
- ☐ Adjustment to the university
- ☐ Alcohol/ Drug Concerns
- ☐ Anger Management
- ☐ Anxiety, fear, nervousness
- ☐ Assertiveness
- ☐ Body image
- ☐ Choice of major/ career
- ☐ Concentration
- ☐ Confusion of beliefs/ values
- ☐ Death of a significant person
- ☐ Delusions
- ☐ Depression
- ☐ Domestic Violence
- ☐ Eating Disorder
- ☐ Ethnic/ racial discrimination
- ☐ Family concerns
- ☐ Financial problems
- ☐ Gender identity/ expression
- ☐ Hallucinations
- ☐ Homicidal Thoughts
- ☐ Irritability, hostility
- ☐ Learning problem or disability
- ☐ Medical Problem
- ☐ Paranoia
- ☐ Physical health problems
- ☐ Procrastination/ Motivation
- ☐ Pregnancy/ Fertility
- ☐ Rape/ sexual assault
- ☐ Relationship Concerns
- ☐ Religious/ Spiritual concerns
- ☐ Safety concerns
- ☐ Self-esteem/ Self-confidence
- ☐ Self-injury/ cutting behavior
- ☐ Sexual concerns
- ☐ Sexual harassment
- ☐ Sexual Orientation
- ☐ Sexually transmitted infection(s)
- ☐ Shyness/ social discomfort
- ☐ Sleep problems
- ☐ Stress Management
- ☐ Suicidal thoughts
- ☐ Tobacco use

**If reasons for appointment are not listed above, please briefly describe:**

**Have you had prior counseling or psychotherapy?** □ **Yes** □ **No** (If yes: Where, When, How Long and Why?)

**Prior hospitalizations:** **Yes**___ **No**___ (If yes: Where, When, How Long and Why?)

**History of Family Mental Illness** (please describe):

**Past and Current Significant Illness/ Surgery/ Allergies** (please specify):

**ALCOHOL AND OTHER DRUG USE (Circle the answer that is correct for you):**

**How often did you have a drink containing alcohol in the past year?**
Never (0) Monthly or less (1) Two to four times a month (2) Two to three times per week (3) Four or more times a week (4) _____

**How many drinks containing alcohol did you have on a typical day when you were drinking in the past year?**
1 or 2 (0) 3 or 4 (1) 5 or 6 (2) 7 to 9 (3) 10 or more (4) _____

**How often did you have six or more drinks on one occasion in the past year?**
Never (0) Less than Monthly (1) Monthly (2) Two to three times per week (3) Four or more times a week (4) _____

**Have you used drugs (over the counter or prescribed) other than those required for medical reasons?** **Yes**_____ **No**_____

**Medications** (Including herbal remedies/ supplements)? □ **Yes** □ **No** (If yes, please list and indicate if current of past):

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## EDUCATION:

| | | | | |
|---|---|---|---|---|
| High School: | Name: | | Dates: | |
| Previous College(s): | Name: | | Dates: | |
| | Name: | | Dates: | |
| | Name: | | Dates: | |

## FAMILY INFORMATION:

**Your current relationship status:** *(Check all that apply)*
☐ Single ☐ Dating ☐ Cohabitating/partnered ☐ Married
☐ Divorced ☐ Separated ☐ Widowed

**If partnered/ Married:** How long? _____ Partner's Name: _____ Age: _____

**Are your parents:** ☐ Together ☐ Separated ☐ Divorced ☐ Widowed

If divorced or separated, when? _____ Your age then? _____

| | FIRST AND LAST NAME | AGE | BIOLOGICAL (B) STEP (S) HALF (H) ADOPTIVE (A) | CITY/ STATE | OCCUPATION | ILLNESS/ DECEASED (If deceased, cause and age) |
|---|---|---|---|---|---|---|
| **PARENT** | | | | | | |
| **PARENT** | | | | | | |
| **PARENT** | | | | | | |
| **PARENT** | | | | | | |
| **#1 SIBLING** | | | | | | |
| **#2 SIBLING** | | | | | | |
| **#3 SIBLING** | | | | | | |
| **#4 SIBLING** | | | | | | |

**Would you like to sign up to receive our health newsletter by email?**

Yes _____ No _____ Email: _____

**SIGNATURE:** _____ **DATE:** _____/_____/_____
MONTH DAY YEAR

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## INFORMATION ABOUT COUNSELING SERVICES

Welcome to Counseling Services of The New School. The Counseling Services offers free professional services for students wanting help with any personal or psychological concerns. All services are available to students who are enrolled in Student Health Services (SHS). If you have any questions about the information below, please don't hesitate to discuss them with the therapist in your initial session.

## YOUR FIRST VISIT – THE INTAKE PROCESS

Your first visit with the therapist will last between forty-five minutes to an hour. You will have the opportunity to describe your current concerns or problems. Your therapist will also gather background information to best understand your needs. A treatment plan will then be developed and discussed with you.

## SESSION LIMITS

All students who pay the SHS fee are entitled to 12 sessions per academic year, or a referral if alternative treatment is clinically indicated. However, due to the volume of students seeking counseling, the following restrictions apply:

- *Students who are seen for 12 sessions during the summer semester must wait until the spring semester before they can be seen for another round of sessions.*
- *When there is a waiting list, priority will be given to students who have never been seen before.*
- *There is no guarantee that students returning for 12 new sessions will be able to see the same therapist they met with in the past.*
- *Students in crisis will be seen regardless of session limit.*

## WALK-IN HOURS

Monday – Friday from 1:45 PM – 2:45 PM students can come into the clinic without an appointment and be seen for a brief assessment. At the end of this assessment the therapist will discuss recommendations. An intake appointment may be scheduled, a referral for treatment outside of Counseling Services may be recommended, or other plans as appropriate.

## YOUR PSYCHOTHERAPIST

The professional staff of Counseling Services is comprised of licensed clinical social workers, psychologists, an art therapist and a psychiatrist. Your therapist may also be a doctoral psychology extern or social work intern working under the supervision of a psychologist or clinical social worker. In order to see the psychiatrist you need to be in treatment with one of our therapists. If you want to meet with a psychiatrist, but don't want therapy, you will be referred to an appropriate psychiatrist outside Student Health Services.

## KEEPING APPOINTMENTS

Requests for counseling appointments are high and our therapists are usually booked. Because counseling appointments are in such demand, a missed session will count as one of your regular sessions unless cancelled more than 24 hours prior to your appointment. Please notify your therapist well in advance if you cannot keep an appointment.

Please sign your name below to indicate that you have read and understand the above information.

Signature: _____ Date: _____/_____/_____
Month Day Year