Counseling Questionnaire

Participant Name

Program Location and Session

PART I: AUTHORIZATION: - to be completed by Participant

By my signature below, I hereby specifically authorize my counselor, psychologist, or psychiatrist, __________________________ (“Mental Health Provider”), of __________________________ (City, State) to release confidential patient information and/or medical records pertaining to myself, __________________________ (“Participant”) to The School for Field Studies, Inc. (“SFS”), or its representative, to the extent necessary for the Provider to complete the foregoing form and to assess the appropriateness of SFS for the Participant at this time. Furthermore, I hereby expressly authorize the Provider to release such additional information as the Provider deems necessary or appropriate to respond to any additional questions SFS may have regarding whether SFS is appropriate for the Participant based on the release of information authorized by this form. I also give SFS permission to discuss this medical information with a medical consultant designated by SFS. I recognize that this information may be protected by state and federal regulations, and that I am hereby waiving such rights. I understand that I may revoke this authorization at any time (except retroactively), and, in any event, this authorization will expire automatically one year from the date signed.

Participant Signature: __________________________

Date: ______________

Please note: If your Provider requires a separate form for release of information and permission for further discussion, please complete those forms with your Provider.

PART I: COUNSELING QUESTIONNAIRE: - to be completed by the counselor, psychologist, or psychiatrist of any SFS student currently in counseling or who has been in counseling at any point in the past three years.

GENERAL INFORMATION

Student/Client Name: __________________________ Date: ______________

Date of First Session: ______________ Date of Most Recent Session: ______________ Frequency of Sessions: ______________

Currently in Therapy?: YES NO

PROGRAM INFORMATION for PARTICIPANTS and MEDICAL PROFESSIONALS

Participants attending The School for Field Studies, Inc. (SFS) engage in rigorous academic programs while based at SFS’s international field stations. These centers are rustic and remote. Because of their remoteness, and because programs often take place in developing countries, transportation to modern medical care is sometimes difficult and may take as long as 24 hours. Mental health counseling and other specialty medical services are not readily available.

SFS programs involve physically and often emotionally, rigorous conditions. There is limited personal time and personal space. The challenges participants may expect to experience include group living, academic deadlines, extreme climates, heat, sun, biting and stinging insects, swimming, strenuous physical activity, hiking, and field work in rugged terrain. Exposure to tropical and regional illnesses such as malaria, dengue, leishmaniasis, giardia, and others are possible. Prior physical conditioning is recommended, and a flexible and enthusiastic attitude is a necessity.

Please note that all SFS students are required to sign a release form giving permission for appropriate SFS personnel to conduct a medical review and approval prior to program participation, as well as to obtain any additional information necessary while the student is on program.
ISSUES OF CONCERN

If any of the following issues apply or have applied to your client, please provide additional information.

1. SUICIDALITY

   Ideation: YES NO  Gesture/attempt: YES NO  Self-mutilation: YES NO

   Date of most recent incident: ___________________________

   If previous incidents occurred, how many?: _______________

   Precipitating factors: __________________________________

   Was the client hospitalized? YES NO

   If yes: What were the dates of hospitalization: ____________  Was discharge routine?: ____________

   Is the client currently at risk? YES NO

   Why or why not?: ______________________________________

2. SUBSTANCE ABUSE

   History: YES NO  Current: YES NO

   Substance of choice: __________________________________

   Has the client ever been assessed for chemical dependency? YES NO

   Was the client ever hospitalized for substance abuse? YES NO

3. BULIMIA/ANOREXIA NERVOSA

   History: YES NO  Current: YES NO  In remission: YES NO

   Date of most recent episode: ________________

   Precipitating factors: __________________________________

   Manifested symptoms: __________________________________

   Was the client ever hospitalized for this condition? YES NO

   If yes: What were the dates of hospitalization: ________________
4. MAJOR DEPRESSIVE EPISODE

History: YES NO  Current: YES NO  In remission: YES NO

Date of most recent episode: ____________________

Precipitating factors: ____________________________________________

________________________________________________________________

________________________________________________________________

Manifested symptoms: ____________________________________________

________________________________________________________________

________________________________________________________________

Was the client ever hospitalized for this condition? YES NO

If yes: What were the dates of hospitalization: ____________________

5. DSM-5 DIAGNOSIS

Diagnosis: YES NO  Current: YES NO  In remission: YES NO

Manifested symptoms/behaviors: __________________________________

________________________________________________________________

________________________________________________________________

Possible manifestations during the program: _________________________

________________________________________________________________

________________________________________________________________

CONTRAINDICATIONS FOR PARTICIPATION

Are there any contraindications to your client’s participating fully in this program: YES NO

If you believe that your client can participate in this program, are there any special accommodations or supports that your client will require, or that will be helpful to them? Please explain.

________________________________________________________________

________________________________________________________________

________________________________________________________________

May we contact you with further questions? YES NO

Mental Health Provider’s Name (Please Print): _______________________

Discipline: ______________________________________________________

Email Address: ___________________________________________________

Office Phone Number: ____________________________  Office Fax Number: __________________

Signature: ____________________________________________  Date: __________

Please submit by fax to: 978-232-1254 “Attn: Safety Department” or by post mail to: The School for Field Studies, Attn: Safety Department, 100 Cummings Center, Suite 534-G, Beverly, MA 01915