THE SCHOOL FOR FIELD STUDIES

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.

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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: _____

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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