

ISU-Pocatello Counseling Center

1400 E. Terry Dr., Bldg. 63

Garrison Hall, 7th Floor

Pocatello, ID 83209

208.240.1609

Welcome to the ISU-Pocatello Counseling Center. The following notice is an introduction to your rights and responsibilities as a client at the clinic. The ISU-Pocatello Counseling Center serves dual functions: to provide counseling for the community and to aid in the professional development of counselors and supervisors. All counseling is facilitated by graduate students at the Masters level who are supervised by a counseling professor. *All counseling sessions at the ISU-Pocatello Counseling Center are video-taped for supervisory and educational purposes*

ISU – Pocatello Counseling Clinic

Department of Counseling
1400 E. Terry Dr., Bldg. 63
Garrison Hall, 7th Floor
Pocatello, ID 83209

CLIENT INTAKE INFORMATION

Please answer all information as completely as possible. Information given is strictly confidential within the limits of the law and beneficial in providing the best possible service. Feel free to ask for assistance. Your counselor will discuss your responsibilities with you in your initial session.

Idaho State University Counseling Clinic does not get involved with any legal or disability-related issues or claims.

CLIENT INFORMATION

Client Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Preferred Pronoun (eg: she, he, ze, they): _____

Self-identified Gender: _____ Sexual Orientation: _____ Primary Language: _____

Parent/Guardian Name (If client is a minor): _____ Cell phone: _____
May call: Yes No
May leave message: Yes No

Client Address: _____ Home phone: _____
May call: Yes No
May leave message: Yes No

Email: _____
May email: Yes No

Current Occupation: _____ Level of Education Completed: _____

Relationship status (ex: Single, married, divorced, separated, significant relationship/s, etc.): _____

In case of emergency, please contact: _____

Name	Relationship	Phone
Have you received prior counseling? <input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, please explain: _____	

Was it helpful? No Yes Please explain: _____

PRESENTING PROBLEMS AND CONCERNS

Please describe your reason for seeking counseling at this time and how you will know if it is working:

Have you ever or are you currently contemplating ending your life? No Yes

Has anyone in your immediate family attempted or completed suicide? No Yes If yes, when? _____

Please circle any of the following that are currently troubling you: For all of those which you circle, please indicate on a scale from 1 to 10, with 10 being significant, how severe you feel this issue is in your life at the present time.

Abuse	Family	Motivation	Stress
Alcohol/Drug use	Fear	Perfection	Study habits
Anger/Rage	Finances	Procrastination	Suicidal thoughts
Anxiety/Panic	Friends	Relationship	Test anxiety
Appearance/Weight	Grades	Sadness	Time management
Assertiveness	Grief	Self-esteem	Trust
Boredom	Guilt	Sexual harassment	Unhappiness
Career	Helplessness	Sexuality	Worry
Dating	Homesickness	Shyness	Other:
Depression	Hopelessness	Sleep	Other:
Eating problems	Loneliness	Stalking	Other:
Expressing feelings	Meeting people	Staying in school	

Present Family/ Living Situation

Please identify the people currently living with you and the nature of your relationship.

	Name	Age	Relationship	Currently this relationship is: Good, neutral, conflicted, etc.
1				
2				
3				
4				
5				
6				

HISTORY

Health

Are you currently under the care of a medical doctor or other medical health professional: No Yes

Name of Primary Care Physician: _____ Physician Phone : _____

Are you currently taking any prescription medications, vitamins or herbal supplements ? No Yes

If yes, please list each medication below

_____ mg _____ Prescribed for: _____ By: _____

_____ mg _____ Prescribed for: _____ By: _____

Do you have any allergies? No Yes If yes, please list: _____

Date of last physical exam: _____ Any significant results: _____

Physical disability: No Yes Chronic illness: No Yes

If yes to either, please explain: _____

Prior psychiatric hospitalizations? No Yes If yes, when: _____

Do you currently exercise: : No Yes If yes, please indicate what type and how many times per week: _____

Are you having any problems with your sleep habits? No Yes If yes, please explain:

Sleeping too little Sleeping too much Poor quality sleep Disturbing dreams Other _____

Are you having any difficulty with appetite or eating habits? No Yes If yes, please explain:

Have you or are you currently using any of the following substances?

Substance	Past or Present use?	Frequency/Amount	Method of use	Level of concern
Caffeine <input type="checkbox"/> No <input type="checkbox"/> Yes				
Alcohol <input type="checkbox"/> No <input type="checkbox"/> Yes				
Tobacco <input type="checkbox"/> No <input type="checkbox"/> Yes				
Recreation or Street Drugs <input type="checkbox"/> No <input type="checkbox"/> Yes (Please list)				

Legal

Have you ever been the victim of a crime? No Yes If yes, please list date and briefly describe:

Are you currently involved in divorce or child custody proceedings? No Yes If yes, please explain:

Have you ever been convicted of a misdemeanor or felony? No Yes If yes, please explain:

Cultural Beliefs Affecting Treatment

What culture do you identify with?

Strengths and Interests

What are your strengths and interests?

GOALS

What are the goals you hope to achieve in counseling:

- 1.
- 2.
- 3.

Is there anything you would like to add that I have not asked which you would like to include?

Client Signature: _____ Date: _____

Parent/Guardian Signature if under 18: _____ Date: _____

Parent/Guardian Signature if under 18: _____ Date: _____

Thank you for your time!

Fee for Service: This agreement shows my commitment to pay for services. I agree to pay in cash or check, \$20.00 per session for Individual Therapy. I understand that payment is due at the beginning of each session and accept that I am fully responsible for this fee.

Limitations of Service Provided by ISU-Pocatello Counseling Center: I understand that ISU-Pocatello Counseling Center is a training facility and therefore some counseling services are not provided. Services not provided include, but are not limited to, issues pertaining to parental fitness and custody, court or legally mandated mental competency evaluation, counseling pertaining or associated with criminal proceedings. Further, I understand that other services may not be provided based on the clinical judgment of my student counselor's supervisor and/or faculty of Idaho State University. I understand that, in the event that such services are required, I will be provided with a list of referrals.

My initials below indicate I have read the following materials, which have been provided to me by this student counselor:

1. _____ Informed Consent 2. _____ Permission to Record Sessions
My signature below indicates that I understand and agree with all of the above points.

Client Signature

Date

I, the student counselor, have discussed the issues above with the client. My observations of this client's behaviors and responses give me no reason, in my professional judgment, to believe that this person is not fully competent to give informed and willing consent.

Student Counselor Signature

Date

ISU-POCATELLO COUNSELING CLINIC

Department of Counseling
1400 E. Terry Dr., Bldg. 68
Pocatello, ID 83209
(208) 240-1609

AGREEMENT FOR COUPLE/FAMILY THERAPY

I, _____, the client, agree to meet with the Student Counselor named below at the appointment times and places we agree on, starting on _____, 20____ for approximately _____ sessions of _____ minutes each.

I have read the following materials on the therapy, which have been provided to me by this counselor:

1. Notice of Privacy
2. Consent to Video Tape
3. Limits of Confidentiality

I believe I understand the basic ideas, goals, and methods of this counseling. I have no important questions or concerns that the counselor has not discussed. In my own words, I understand the following:

With enough knowledge, and without being forced, I enter into treatment with this counselor, I will keep my counselor fully ip to date about any changes in my feelings, thoughts, and behaviors. I expect us to work together on any difficulties that occur, and to work them out in my long-term best interest.

Duration of Treatment: At the end of _____ meetings, we will evaluate progress and may change parts of this agreement as needed. Our goals may have changed in nature, order of importance, or definition. If I am not satisfied by our progress toward goals, I will attempt to make change in this agreement, and I may stop treatment after giving this counselor at least 7 days' notice of my intentions and meeting with the counselor for one last time.

Fee for Service: This agreement shows my commitment to pay for this counselor's services. It also shows this counselor's willingness to use and share his or her knowledge and skills in good faith. I agree to pay in cash or check, \$15.00 per session for Individual Therapy/\$20.00 Couple/Family Therapy. I understand that payment is due at the beginning of each session. I understand and accept that I am fully responsible for this fee.

Videotaping of Sessions: I also give my permission for the counselor to videotape our sessions for personal review, supervision, and limited educational purposes. All who may view these videotapes are bound by the legal framework of privacy and confidentiality. I understand that any information in this recording that could identify me in any way will not be published or given our without my written consent. I understand that all video recordings of these sessions will be destroyed at or before the conclusion of my counseling with this counselor.

Limitations of Service Provided by ISU-Meridian Counseling Center: I understand that ISU-Pocatello Counseling Center is a training facility and therefore some counseling services are not provided. Services not provided include, but are not limited to, issues pertaining to parental fitness and custody, court or legally mandated mental competency evaluation, counseling pertaining or associated with criminal proceedings. Further, I understand that other services may not be provided based on the clinical judgment of my counselor's supervisor and/or faculty of Idaho State University. I understand that, in the event that such services are required, I will be provided with a list of referrals.

My signature below indicates that I understand and agree with all of the above points.

Signature of client

Date

I, the counselor, have discussed the issues above with the client. My observations of this client's behaviors and responses give me no reason, in my professional judgment, to believe that this person is not fully competent to give informed and willing consent.

Signature of counselor

Date

ISU-POCATELLO COUNSELING CLINIC
Department of Counseling
1400 E. Terry Dr., Bldg. 68 Pocatello, ID 83209 | (208) 240-1609

INFORMED CONSENT
Please read every section and initial each line.

_____ **What to Expect:** Appointments are 50 minutes in duration, once per week, at a regularly scheduled time, although schedules may be more or less frequent as needed. You are expected to arrive on time and your session cannot be extended due to late arrival. If you need to cancel your appointment please leave a message on the clinic voicemail, (208) 240-1609, at least 24 hours before your scheduled session.

The ISU Pocatello Counseling Clinic is open when school is in session during the fall, spring, and summer semesters and is not staffed during school holidays. This may mean you will not be able to see your student counselor for one to four weeks between semesters. Your student counselor will work with you in advance to plan for these breaks and provide referrals if needed.

You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, or national origin. Your student counselor is a safe person to talk with about any of these topics. The ISU Pocatello Counseling Clinic is a designated Safe Zone; a program designed to increase awareness, affirmation, and acceptance of those who identify as lesbian, gay, bisexual, trans, and/or experience their gender identity and/or sexual orientation on a continuum.

The ISU Pocatello Counseling Clinic is a teaching facility made up of master's and doctoral level students working towards their degrees. As students progress or graduate they will no longer continue to work in the clinic. Student counselors will inform you in advance of any changes in their availability. If the need arises for the student counselor to transition out of the clinic, they will work closely with you to create an individualized plan to support you with your goals for counseling.

_____ **Risks and Benefits:** There is a possibility of risks and benefits which may occur in counseling. Counseling may involve the risk of remembering unpleasant events; arouse strong emotional responses; and impact client's relationships. The benefits from counseling may be an improved ability to relate with others; develop a clearer understanding of self, values, goals; increased academic productivity; and an ability to deal with everyday stress. Speaking honestly about your experience will increase your student counselor's ability to assist you.

_____ **Limitations of Service:** The student counselors at the ISU Pocatello Counseling Clinic are not licensed counselors. All are master's level and/or doctoral students working under the supervision of licensed counselors in faculty or doctoral student positions. Your student counselor is unable to diagnose, provide insurance billing, evaluate for parental fitness and custody, court or legally mandated services, or offer counseling pertaining to criminal proceedings.

_____ **Payment and Billing:** Payment is due at the beginning of each counseling session and your student counselor is unable to see you without payment. We are unable to bill insurance at ISU Pocatello Counseling Clinic. If you are unable to afford the fee please discuss this situation with your student counselor and we may be able to provide sliding scale, or pro bono services, on a limited basis. You may not carry forward a credit; please pay for each counseling session individually.

_____ **Crisis Communication:** To contact your student counselor please call the Clinic voicemail, (208) 240-1609, and leave a message. Your student counselor will return your call in a timely manner. We are unable to provide emergency services. If you have an emergency, please call 911 or go to your nearest emergency room.

_____ **Electronic Communication:** PCC staff will not interact with clients via social media. Any social media presence by PCC or staff members will not be continuously monitored and will not be utilized as a means of communication between client and clinician. In addition, PCC staff will not utilize text messaging, instant messaging, Snapchat, or similar communications to interact with students. Students may opt to be contacted by a voice phone call or, by client request, email. Email will only be used for scheduling purposes and not as a form of communication about therapeutic issues or for crisis intervention. Staff do not monitor email outside of regular business hours and may not check email consistently throughout the day.

I have read and understand the ISU Counseling Clinic Informed Consent.

Client Signature

Date

Parent/Guardian Signature (Required if client is a minor)

Date

Student Counselor Signature

Date

ISU-Pocatello Counseling Center

Garrison Hall, 7th Floor
1411 E. Terry Dr., Bldg. 68
Pocatello, ID 83209
208.240.1609

Limits of Confidentiality in Counseling

The ISU-Pocatello Counseling Center abides by the ethical codes established by the American Counseling Association as well as the rules and statues governing the practice of counseling in the State of Idaho. These ethical codes and legal statues require counselors to report to responsible persons or state agencies when clients indicate any of the following situations:

- **That the client intends to harm self**
- **That the client intends to harm someone else**
- **Information as to direct involvement in child abuse or neglect**
- **Information as to direct involvement in abuse of the elderly**
- **Information as to direct involvement in abuse of the disabled**

Confidentiality is also limited by the use of supervisory sessions involving practicum students, interns and supervisors. Confidentiality may be limited as mandated by the courts or, in the case of minors, when parents may have access to counseling information.

By signing below, I indicate that I understand my limits of confidentiality and I am aware of the certain situations where the counselor must breach my right to confidentiality in the counseling relationship with or without my permission.

Client _____ Date _____

Parent/Guardian (if client is a minor, a parent/guardian signature is required) _____ Date _____

Counselor _____ Date _____

ISU-POCATELLO COUNSELING CLINIC
Department of Counseling
1400 E. Terry Dr., Bldg. 68, Pocatello, ID 83209 | (208) 240-1609

PANOPTO FAQ

What is Panopto?

Panopto is video content management system (VCMS). This means that users* of Panopto are able to record and or upload video sessions to an online storage system.

How does Panopto work?

Panopto allows users to log in to a password protected webhosted service to upload videos via a secure connection. Users are assigned a folder to which they can save their videos. These videos can then be played back online.

How does ISU's Department of Counseling protect the video sessions?

We secure videos through a combination of methods. Our first method is to assign each user a unique password that only allows them access to their folders, videos, and recording capacity. Second, we restrict the permission to view each user's folder. For example, an intern's folder will only be viewable by the user, their doctoral supervisor, and their faculty supervisor. Third, we will be deleting videos once they have been viewed by the faculty supervisor or the current semester of study expires. Lastly, we enforce strict policies contained within our department's student manual that specifies the locations that videos may be viewed outside of supervision. For example, users are not permitted to play back videos in public spaces or in the presence of others not associated with their supervision. The viewing of videos is intended to be a private activity.

Your understanding and comfort using Panopto is important to us and we wish to continue providing education and training on how to make the use of Panopto as successful as it can be. If at anytime you have questions, please feel free to contact the following individuals

ISU Meridian Department of Counseling's Clinic Director. Dr. Shawn Parmanand: (208) 282-1431, shawnparmanand@isu.edu

ISU Department of Counseling's Chair. Dr. David Kleist: (208) 282-4315, kleidavi@isu.edu

ISU Department of Counseling Internship Coordinator. Dr. Randy Astramovich: (208) 282-3075, randyastramovich@isu.edu

ISU Department of Counseling Panopto Technology Coordinator. Chad Yates: (208) 282-3158 yatechad@isu.edu

Is Panopto secure?

Panopto uses SSL** in the web interface to encrypt all sensitive user information. The Panopto server uses password hash checking. Passwords are not stored as plaintext. Although using a server-based video content management system is never 100% safe we feel the use of this system helps us to guarantee a level of security unreachable before now.

Definitions

*Users include the following: counseling master's students enrolled in practicum and internship, ISU counseling department supervisors (assigned doctoral students), and ISU faculty members.

** SSL (Secure Sockets Layer) is the standard security technology for establishing an encrypted link between a web server and a browser. This link ensures that all data passed between the web server and browsers remain private and integral.