



THE ALDERSGATE CENTER

INDIANA WESLEYAN UNIVERSITY

Clinical Counseling Services Intake

Welcome to The Aldersgate Center of Indiana Wesleyan University. This handout summarizes important information that you should know about our services; please take a few minutes to read it. Because The Aldersgate Center serves individuals with a wide range of concerns, some of this information may not be relevant to your particular situation; however, it is important that you read through this material. Should you have any questions about this handout, please feel free to discuss them with your counselor during your first session.

The Aldersgate Center attempts to assist clients in resolving their own problems. We believe that as you and your counselor work together to address your concerns, you will develop a sense of self-awareness that will influence your behavior and feelings. If counseling is successful, you should feel that you are better able to face life's challenges in the future without our support or intervention. Counseling services are generally available on a first-come, first-served basis. If no appointments are available you will be placed on a waiting list and offered a referral to other counseling services (often fee-based) in the area.

Please note that The Aldersgate Center does not provide services that require court testimony/reports or involve legal proceedings.

Sessions are 50 minutes in duration. In the event that you are unable to keep an appointment, please notify The Aldersgate Center office at least 24 hours in advance.

Our staff counselors are all trained therapists, who hold licenses or are working towards licensure. Our graduate student interns are closely supervised by our staff counselors.

I have read the above material regarding rights and responsibilities of The Aldersgate Center clients and understand its provisions.

I understand that the results of counseling can be variable, and that the attainment of a positive outcome is dependent upon the effort expended by both my counselor and myself. While it is impossible to guarantee any specific results regarding your goals, together we can work toward growth and change.

The Aldersgate Center assures you that our services will be rendered in a professional manner consistent with accepted ethical standards.

Please sign that you have read and agree to the above statements.

Signature	Date	Time	ID#
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Print Name	Box #	Cell#/Extension
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Credit Hours (this term)	Major/s	Campus Residence	Hometown
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Please circle one: Freshman Sophomore Junior Senior

Current areas of concern. May check more than one. Please circle top concern.

- | | |
|--|---|
| <input type="checkbox"/> Academic/Educational | <input type="checkbox"/> Financial |
| <input type="checkbox"/> Alcohol/Other Drug Concerns | <input type="checkbox"/> Legal |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Loneliness |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Loss/Grief/Death |
| <input type="checkbox"/> Career/Job Related | <input type="checkbox"/> Medical/Physical |
| <input type="checkbox"/> Cultural/Cross-Cultural | <input type="checkbox"/> Physical Abuse/Assault |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Racial |
| <input type="checkbox"/> Discrimination/Harassment | <input type="checkbox"/> Sexual Concern |
| <input type="checkbox"/> Eating Issues/Body Image | <input type="checkbox"/> Spiritual/Religious |
| <input type="checkbox"/> Family | <input type="checkbox"/> Other |

Have you had previous counseling? Yes No

When _____ With Whom _____

For how long? _____

Are you currently taking prescribed or over the counter medications? Yes No

If Yes: Name of medicine _____ For what reason: _____

Do you have any medical problems? Yes No

If Yes, Describe:

- | | |
|--|--|
| Have you ever had a problem with alcohol or other drugs? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Are you currently experiencing thoughts of hurting yourself? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have you ever experienced thoughts of hurting yourself? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have you ever attempted suicide? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Are you experiencing thoughts of hurting others physically? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have you ever physically hurt others? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Briefly describe your problem:

What do you want to accomplish through counseling?

