Atlanta Metropolitan College
1630 Metropolitan Parkway, SW
Atlanta, Georgia 30310

Department of Counseling and Disability Services

INTAKE FORM

Today's Date_____

Student _____
(Last Name) (First Name)

SSN/Student ID #_____ Semester/Year

Male____ Female_ Date of Birth Age_

Current Address _____

Phone: _____ O.K. to leave message on answering machine _____
E-mail: _____

Current Marital Status: _____ Spouse's Name (if applicable)_____
Number of Dependents_____ Ages_____

Academic Class (Please check)
Freshmen_____ Sophomore_____
Major_____

Referral Source: Self_____ Other (please specify)
_____

Emergency Contact
Name_____ Relation_____ Phone #_____

Your Permanent Address_____
_____

Reason for seeking counseling: _____
_____
_____

Physical/Emotional History
Are you now under a doctor's care?_____If yes, name of doctor_____

Are you taking any medication?_____If yes, what kind?_____

Have you been treated for emotional disturbances?_____If yes, when?_____

Have you had any thoughts of suicide?____If so, when_____ Do you have any thoughts now?_____

Atlanta Metropolitan College **AMC Counseling Services**
Department of Counseling and Disability Services
1630 Metropolitan Pkwy, SW/ Atlanta, GA 30310-4498/ (404) 756-4016/ Fax (404) 756-4939

INFORMED CONSENT FOR COUNSELING SERVICES

Last Name	*First Name*	*Middle Initial*	*AMC ID*	*Date*

Introduction
Welcome to the Counseling and Disability Services Center at Atlanta Metropolitan College. This informed consent document is intended to give you general information about our counseling services. This is a legal document; please read it carefully before signing. If you have any questions about signing this document and/or would like a copy of this document, please ask your counselor.

Eligibility
I understand that eligibility for services is contingent upon my status as an enrolled or continuing AMC student.

Provision of Services
I understand that AMC offers a variety of services to students including: intake assessment, short term individual counseling (up to 8 sessions per academic year), crisis intervention, workshops and referrals. During the initial assessment, my AMC counselor and I will work together to determine how best to serve my needs. I further understand that an appropriate referral will be provided to me if it is determined that I would be best serviced by a community resource.

Nature of Counseling
I understand that there may be both risks and benefits associated with participation in counseling. Counseling may improve my ability to relate with others, provide a clearer understand of myself, my values, and my goals, and an ability to deal with everyday stress. I understand that counseling may also lead to unanticipated feelings and change, which might have an unexpected impact on me and my relationships.

Confidentiality
I understand that AMC counselors maintain confidentiality in accordance with the ethical guidelines and legal requirements of their profession. Effective counseling sometimes requires that staff members share confidential information with other staff members. I may give AMC Counseling Staff written permission to share information with others such as; AMC faculty and administration, family members, or other health care providers. However, I may revoke permission for the AMC Counseling Center to exchange information with these individuals at my discretion.
I understand that no records or information about me will be released from AMC without my permission, **except under certain circumstances.**

If I present a serious danger to myself or another person.
If my provider suspects that a child, dependent adult or elder is being abused (physically or sexually) or neglected, they are required by law to make a report to the proper authorities.
If I am under 18 years of age and disclose abuse or neglect to my counselor.
If a valid subpoena is issued for my records, or my records are otherwise subject to a court order or other legal process requiring disclosures.

Please Note: The exceptions to confidentiality are extremely rare. However, if they should occur it is the Center's policy that, whenever possible, we will discuss with you any action that is being considered. Legally we are not obligated to seek your permission, especially if such a discussion would prevent us from securing your safety or the safety of others. If disclosure of confidential information does become necessary, we will release only the information necessary to protect your and/or another person's physical safety.

Student Initials: ☐

Attendance Policy and Cancellations

I agree that while I am seeing a counselor or participating in a group, whenever possible, I will notify AMC (by calling 404-756-4016) at least 24 hours in advance if I know I will miss a session. I understand that if I do not show for an individual session and do not call, it will count towards my allotted number of sessions.

Counseling Files

Counseling files are **NOT** part of academic records, and no one has access to them except the staff of the AMC Counseling Center. Records are kept for the period required by ethical and legal guidelines; that period is presently 7 years.

Contacting Me

In order to keep my relationship with AMCCC confidential, the best way to contact me should the need arise is noted below. I am aware that information exchanged over a cell phone and e-mail could be intercepted by an outside party.

Okay to leave a message if I am unavailable:	**Please check all that apply**	
	Yes	**No**
Cell Phone: _____	☐	☐
Residential Phone: _____	☐	☐
Work Phone: _____	☐	☐
E-mail Address: _____	☐	☐
Other Phone: _____	☐	☐

If there are any concerns with AMC Counseling Services that you cannot discuss with your counselor, Please contact the Director of the Counseling and Disability Services at (404) 756-4016.

Consent

I certify that I have read, understand, and agree to abide by the information outlined above regarding my eligibility and use of the College Counseling Services. I hereby give my consent to authorize the College Counseling Services to evaluate, treat, and/or refer me to others as needed. I have had the opportunity to discuss any questions regarding the above information.

_____ _____

Student Signature Date:

ATLANTA • METROPOLITAN • COLLEGE

Believe • Begin • Become

University System of Georgia

Atlanta Metropolitan College
1630 Metropolitan Parkway, SW
Atlanta, Georgia 30310

Department of Counseling and Disability Services

AUTHORIZATION FOR RELEASE OF INFORMATION FORM

Student/Client's name (print) _____ DOB ____/____/____

SS# or Student ID #_____

I hereby request and authorize **Atlanta Metropolitan College** and their designated staff to share information with and to obtain copies of written reports/evaluations from the following:

_____
(Health Care Professional's Name)

_____
(Agency or Health Care Facility)

Written information may include but is not limited to: **Psychological evaluation(s), Psychiatric evaluation(s), Individual Education Plans (IEP)s, all testing, recommendations, school records, medical records, special education records, and any other relevant or requested information for the purpose of determining appropriate treatment recommendations, accommodations, or referrals.**

Other: _____

_____

I authorize the above mentioned entities to share information by phone, in person, fax and/or email contact. I understand that all information will be held strictly confidential and cannot be released by the recipient without my written consent. I understand that this authorization will remain in effect for the period of time that I am enrolled as a student at Atlanta Metropolitan College.

I understand that I may withdraw this consent at any time.

_____ _____
Signature of Student Date

_____ _____
Signature and relation of witness Date

_____ _____
Signature of counselor Date

USE THIS SPACE ONLY IF STUDENT/CLIENT WITHDRAWS CONSENT

_____ _____
Signature of Student/Client **Date**

Department of Counseling and Disability Services
Atlanta Metropolitan College
1630 Metropolitan Parkway, SW
Atlanta, Georgia 30310

FERPA RELEASE OF INFORMATION FORM

Student ID #_____

I _____ hereby request and authorize **Atlanta Metropolitan College** and
(First, Middle, Last Name)

their designated staff to share information with _____.
(Parent/Guardian's Name)

Address of Releasee (Parent/Guardian): _____
_____
_____

1. Description of Information to be released:

_____
_____
_____

2. Reason for release of information:

_____
_____

3. Release Information for period of: (Check One)

___ One Semester (Valid from_____to _____)
___ One Time Use

Other Restrictions and Conditions:

This Consent to Release Records is limited to those persons expressly named herein. Any further release of records/information to any other person, group, corporation or entity of any kind or nature is expressly prohibited without the further written consent of the student. The records listed above will be released in unedited form except as otherwise provided by the Family Educational Rights and Privacy Act of 1974 and regulations promulgated there under applicable state law, and the policies and procedures of the University. THE STUDENT HAS THE RIGHT TO DENY ACCESS TO THE INFORMATION LISTED ABOVE AND/OR TO REVOKE THIS CONSENT AT ANY TIME. In signing this consent form, the student and/or the student's legal guardian agrees to permit the release of information.

I authorize the above mentioned entities to share information by phone, in person, fax and/or email contact. I understand that all information will be held strictly confidential and cannot be released by the recipient without my written consent. I understand that this authorization will remain in effect for the time period designated and that my consent may be withdrawn at any time.

_____ _____
Signature of Student Date

_____ _____
Signature of Parent or Guardian Date

_____ _____
Signature of Counselor Date

USE THIS SPACE ONLY IF STUDENT/CLIENT WITHDRAWS CONSENT

_____ _____
Signature of Student/Client **Date**

Telephone (404) 756-4783 Facsimile (404) 756-4939

Disability Needs Assessment Questionnaire

Directions: It is imperative that you complete and return this form with a copy of your documentation to the Department of Counseling & Disability Services to have accommodations provided in a timely manner. If you wait, your accommodations may not be approved at the beginning of the semester. More information about documentation may be found on subsequent pages of this form.

Please be sure to complete at least two weeks before the beginning of the term. Please return this questionnaire to the Department of Counseling & Disability Services, Room 225 at 1630 Metropolitan Parkway, Atlanta, GA 30310. You may also fax this form to 404-756-4939.

Name: Current Semester:

Street Address:

City: State: Zip Code:

Home Phone: Cell Phone:

E-mail:

1. **In your own words, describe your physical, mental or learning disability.**

2. **List the accommodations you wish Atlanta Metropolitan College to provide for you during your college career:**

3. **Certain accommodations may require arrangements to be made well in advance. Please contact the Department of Counseling & Disability Services as soon as possible if you check any of the categories listed below. Please attach a separate page to explain the nature of your need.**

Campus mobility, including parking

Special academic equipment or support

Orientation activities or placement testing

Dining Services

Curriculum or course selection

Classroom assignment or class scheduling

Class activities, including faculty presentation and testing

4. **In order to process your request for accommodations, Counseling & Disability Services will consult with the following offices as needed:**

Enrollment Services	Student Support Services	Dining Services	Student Activities
Student Affairs	Academic Affairs	Financial Aid	Academic Advisement Center

We must have your permission to consult with these offices. Please indicate your approval by checking beside each office, and sign and date below.

Signature_____Date:_____

In the event of an emergency evacuation would you require assistance? Yes No

Atlanta Metropolitan College is committed to carrying out the provisions of the Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973, civil rights laws designed to prohibit discrimination on the basis of disability. The determination to qualify a student as a student with documented disability is made on a case-by-case basis after carefully reviewing how the disability currently and substantially limits a major life activity.

General Documentation Guidelines

1. Documentation must be typewritten on business letterhead from a licensed professional not related to the student who is qualified to give psychological and/or medical diagnosis. The name, credentials and signature of the licensed professional must appear on the documentation.
2. The documentation must include all pertinent diagnoses, clearly stated and explained.
3. Information outlining testing/assessment tools must be included. Learning disability testing must include the actual standard test scores; student must be tested using measures normed on adult populations.
4. Documentation must include information on how the disability currently impacts the individual and document "how a major life activity is limited by providing a clear sense of the severity, frequency and pervasiveness of the conditions(s)" (www.ahead.org/resources/best-practices-resources/elements).
5. All pertinent positive and negative effects of mitigating measures must be addressed. This could include a description of treatment, medications (and potential side effects) and assistive devices with estimated effectiveness of their impact on the disability.
6. Documentation should provide recommendations for accommodations for the individual and include the rationale for the recommended accommodations.

Disability	Currency of Documentation	Accepted Evaluator	Elements of Documentation
ADD/ADHD	Within 3 years	Psychologist, psychiatrist, neuropsychologist, medical doctor	Evidence of early impairment from more than one setting; evidence of current impairment; summary of neuropsychological or psychoeducational assessments to determine the current functional limitation pertaining to an educational setting; prescribed medications, dosages and schedules; suggestions of accommodation.
Autism spectrum disorder/Asperger's syndrome	Within 3 years	Developmental pediatrician, neurologist, psychiatrist, psychologist, neuropsychologist	Academic testing – standardized achievements test, including standard scores; impact of symptoms on learning; ability to function in a residential college community; prescribed medications, dosages and schedules that may influence the learning environment.
Chronic illness and physical impairment	Depends on condition	Licensed medical professional	Documentation will vary based on the diagnosis, which would include conditions such as asthma, allergies, arthritis, diabetes, fibromyalgia, migraine, and multiple sclerosis.

Disability	Currency of Documentation	Accepted Evaluator	Elements of Documentation
Hearing impairment	Depends on whether condition is static or changing	Otorhinolaryngologic, otologist, licensed audiologist	Audiological evaluation or audiogram administered by a licensed audiologist; interpretation of the functional implications; suggests of accommodations.
Learning disability	Within 3 years	Clinical or educational psychologist, school psychologist, neuropsychologist, learning disabilities specialist	Assessment must be comprehensive (more than one test) and address *intellectual functioning/aptitude*, preferably the Wechsler Adult Intelligence Scale – III with standard scores; achievement – current levels in reading, math, and written language (acceptable instruments include the Woodcock Johnson Psychoeducational Battery III, Wechsler Individual Achievement Test or others); and information processing utilizing subtests from the WAIS-III, WJ III or other. Individual "learning styles"," learning differences"," academic problems" and "test difficulty or anxiety" do not constitute a learning disability. Please refer to General
Psychiatric disorder	Current diagnosis within 6 months Psychological evaluation within 3 years	Licensed clinical psychologist, psychiatrist, psychiatric advanced practice registered nurse(APRN), licensed clinical social worker	Documentation Guidelines above. Family history; discussion of dual diagnosis; current diagnosis (DSW-IV TR) indicates the nature, frequency, severity of symptoms – diagnosis without an explicit listing of current symptoms is not sufficient; prescribed medications, dosages and schedules that may influence the learning environment; types of accommodations, including any possible side effects.
Visual impairment	Depends on condition	Ophthalmologist	Ocular assessment/evaluation; suggestions on how the condition may be accommodated.

Acknowledgement: *This information is based on the Disability Documentation Guidelines to Determine Eligibility for Accommodations at the Postsecondary Level developed by the Georgia Association on Higher Education and Disability as well as the Association on Higher Education and Disability (AHEAD), which is the national organization for postsecondary disability services.*

r

Atlanta Metropolitan State *College*
1630 Metropolitan Parkway, SW
Atlanta, Georgia 30310

Department of Counseling and Disability Services

Dear Healthcare Provider:

RE: _____

The Department of Counseling and Disability Services at Atlanta Metropolitan College (AMSC) coordinates services for students with disabilities. It is the student's responsibility to provide detailed documentation that thoroughly explains the current status of the disability and resulting functional limitations that suggests appropriate academic accommodations.

We request that you please help this student by furnishing as much of the following information as you may have available and as quickly as possible. Only current documentation on letterhead, signed by an appropriate licensed professional (medical doctors, licensed psychologist, neurologist, counselor or social worker) with expertise and training in psychiatric diagnosis can be accepted. In order to meet the Board of Regents criteria for documentation of a psychological disorder, the following information must be included:

- Diagnosis, including diagnostic codes.
- Medications, and side effects, if any, that this person may be experiencing.
- Functional impairments/limitations, as a result of the disability and/or medications.
- How the impairments/limitations may affect or interfere with academic performance.
- IF appropriate to the diagnosis, a copy of previously administered testing and/or psychological evaluations that confirm the diagnosis, especially testing that details: Intellectual Functioning, Academic Achievement, Auditory Processing, Language Skills, Visual Perceptual/Spatial/Motor Skills, Attention, Learning/Memory, Frontal/Executive Functions, and/or Psychological/Psychiatric Disorders.
- Evidence that rules out alternative explanations for academic problems, i.e. poor study skills; motivational, emotional, mental, or physical problems; and/or cultural/language differences.
- *Suggested* accommodations that may help alleviate the impact on academic performance (refer to the enclosed brochure).

Thank you for helping us to enhance this student's opportunity for academic success.
To access the Board of Regents criteria for documenting disabilities please refer to http://www.usg.edu/academics/handbook/section2/2.22/2.22.04.phtml.
Please contact me for additional information at 404-756-4016. Fax 404-756-4939.

Sincerely,

Dorothy Williams, LPC
Director, Counseling and Disability Services

Atlanta Metropolitan State College
Department of Counseling and Accessibility Services
1630 Metropolitan Pkwy, SW/ Atlanta, GA 30310-4498/ (404) 756-4016/ Fax (404) 756-4939

ACOMMODATIONS RECOMMENDATION AND REFERRAL FORM

Student/Client's Name _____ Student ID _____

Student Referral? _____ YES / NO _____

REFERRED TO:

Name of Agency: _____

Name of Doctor: _____

Address: _____

Telephone Number: _____

Student's Signature _____ Date _____

Counselor's Signature _____ Date _____

_____ Date _____
Signature: MD/Psychologist/Psychiatrist or Licensed Professional

Student Requires Accommodations: YES / NO

ACCOMMODATIONS:

___ Extended Time on All Exams & Quizzes
___ Testing in a Distraction-Reduced Environment
___ Occasional Exception to Absentee/Tardiness Policy
Occasional Extension of Due Date w/Dr's Note
Use of Calculator on Exams
___ CCTV or Enlarged Text for Exams
___ Priority Seating in Classroom

___ Use of Tape Recorder in Class
Professors' slides and notes when available

___ Use of Computer with Spell Check
___ Use of Computer with Grammar Check
Use of Formula/Note Cards

Other _____

_____

Student Participation Agreement

Note: This form is to be reviewed and signed by the student in the presence of his/her disability service provider. Student must initial where indicated. A signed copy of this form must be on file with Disability Service Office before submitting an order for book in alternative formats.

How AMAC Works

The Alternative Media Access Center (AMAC) is an initiative of the University System of Georgia and is committed to removing barriers and providing access to knowledge for individuals with learning, physical, sensory, and print-related disabilities. AMAC partners with the educational institution and acts as a conduit through which the institution provides textbooks in a variety of alternative formats.

- The student is responsible for identifying and registering for classes as soon as possible. Once the class has been selected, the student is responsible for obtaining the required reading list, purchasing the texts and providing that information to the Disability Service Provider ("hereinafter, DSP.")
- The DSP then contacts AMAC and orders the required texts.
- AMAC provides the text in the student's preferred alternative format. However, if the text is not available in that format, then AMAC will provide the next available format.
- Once the text has been converted, if it is in an electronic format, it is posted online to the student's account within the AMAC Student Center. The file will be available to the student for the remainder of the current semester.
- AMAC will notify the recipient of the file transfer using the primary email address on file for the recipient.
- If the material is available on CD, it is transferred to the DSP's office or mailed directly to the recipient using the most current mailing address on file.

Finally, AMAC provides a myriad of hardware and software to assist recipients of its services in accessing text in a variety of alternative formats. Some of these tools may be unfamiliar to you. AMAC has a toll free help line to assist you in using the hardware and software that we provide. You may contact the Customer Support line at 1-866-418-2750 to obtain assistance.

Agreement

I, (student's legal name), understand that I am eligible to receive an accommodation of books in alternative formats through the University System of Georgia Alternative Media Access Center. I also understand that to maintain my eligibility, I must adhere to all of the policies and procedures set forth by the Alternative Media Access Center ("hereinafter, AMAC") for recipients of books in alternative formats. I therefore agree to:

- Register early (if possible) for the upcoming semester, which provides sufficient time for textbooks to be converted;
- Contact each professor or department to find out the title, author, copyright year and ISBN number of any textbook that will be required for the class;
- Request only required readings to be converted into alternative formats;
- Purchase a personal copy of any textbook for which I request alternative formats;
- Advise my disability service provider immediately if any of my courses are changed or dropped;
- Return all disks, CDs, or other materials provided by AMAC by the last day of the semester during which they are used;
- Delete all electronic files (e-files) that I may have downloaded to my computer by the last day of the semester during which they are used.

_____
student initials

- I understand that I must provide my disability service provider with all of the following:

1. A list of required readings prior to the beginning of classes,
2. A copy of each course syllabus (if available) after classes begin, and
3. Copies of receipts for textbooks or materials I am requesting.

_____
student initials

- I understand that AMAC may provide me with certain hardware and/or software to enable me to access my text books in alternative formats. If I am provided with hardware, it must be returned pursuant to the agreement that is provided with the hardware. If I am provided with software I may not share the web site or the password for downloading the software with others. My use of hardware and software provided by AMAC is of limited use and is strictly for the purpose of accessing my textbooks.

_____
student initials

- I understand that my educational institution is ultimately responsible under the law to provide my accommodations and that AMAC is one of the tools employed by that institution to meet their responsibility.

_____
student initials

- I understand that any direct communication between me and AMAC is subject to being shared with members of my educational institution.

_____
student initials

student initials

- I understand that materials provided by AMAC are the property of AMAC and may not be reproduced, redistributed or shared in whole or in part at any time.

student initials

- I understand that if materials provided by AMAC are not returned to AMAC within the agreed upon timeframe, AMAC has the right to notify my educational institution of the unreturned materials, and the educational institution, at its discretion, may take any action that it sees fit, including, but not limited to: flagging my records until the materials are returned, refusing to release my grade in the effected class or any class until the materials are returned, imposing a library fine for each day that the materials are not returned, or, suspending my right to services through AMAC until the materials are returned.

student initials

- I understand that I will contact my disability service provider or the AMAC Technical Support Department concerning any issue that may arise concerning any software, hardware or books obtained through AMAC.

student initials

- I understand and agree to the AMAC Agreement and all policies pertaining to my eligibility.

student initials

- Please be aware that AMAC will require a minimum of three weeks from the receipt of material and agreement forms in order to produce services.

Privacy Agreement

At AMAC, your privacy is our chief concern. We understand that you entrust us with your private medical and/or educational information to help us support you with accommodations.

In exchange for your trust, you expect and deserve our commitment to treat your information with respect. Rest assured that we will protect your privacy. Under no circumstances will AMAC share any personal information about you to or with any person or organization except as authorized by you, to professionals or other parties involved in your transaction.

We want you to be aware of who we are and how AMAC will serve you. Information we may collect on the AMAC website includes your disability type, accommodation needs, and contact information for training support purposes. Your information is used to develop an

accommodation profile you will be able to access in a secure online environment. Only electronic materials, accommodation information, and strategies and solutions will be posted on the profile site.

Please review the information on our website to ensure that our services meet your needs.

_____
student initials

- I grant permission to my Disability Service Office and the Alternative Media Access Center to electronically share information noted on the Participation Agreement and the Materials Request forms between the two agencies.

_____
student initials

- I am aware that information will not be given or transmitted to anyone other than AMAC and the Disability Services Office at which I am currently enrolled per the AMAC Participation Application date.

_____
student initials

- I am aware that by agreeing to participate in AMAC services I may be contacted by AMAC production personnel for training and technical assistance.

_____
student initials

- I am aware that as a result of receiving AMAC services I could be invited to participate in research pertaining to my disability and accommodations, and that I will have the right to refuse participation if I so choose.

Instructions and Signatures

- By signing this form, you, and your DSP, are affirming that you have documentation on file of the student's disability, as well as copies of receipts for all requested texts.
- By signing this form you, the student, are affirming that you have read (or have had read to you) this form, and that you understand and accept the guidelines set forth herein.

Please print and sign this form. Be sure to make a copy for your records.

_____ _____ _____
Student Signature Print Name Date

DSP Signature Print Name Date

Name of Institution: (Name of Institution

Documentation Release

In order for (student name) to receive services through the Alternative Media Access Center (AMAC), I, (service provider) verify documentation is on file at (Institution or agency) supporting that (student name) demonstrates a functional limitation in the ability to access print materials. The documentation for (student name) follows the AHEAD Seven Essentials for Documentation and can be accessed as necessary at any time.

Verification

I, (service provider), verify the following essentials are included in this documentation:

1. The credentials of the evaluator(s)
2. A diagnostic statement identifying the disability
3. A description of the diagnostic methodology used
4. A description of the current functional limitations [requiring alternative media and/or assistive technologies to access print]
5. A description of the expected progression or stability of the disability
6. A description of the current and past accommodations, services and/or medications
7. Recommendations for accommodations, adaptive devices, assistive services, compensatory strategies, and/or items support services

Student Disability(ies)

Primary Print Disability:_____

Secondary Disability:_____

Instructions and Signatures

Please print and sign this form. Be sure to make a copy for your records. Be sure to document the completion of the form on the student's record in

_____

DSP Signature Print Name Date

Approved: yes / no

UGARCL / Print Name Date

Student Counseling Cent

Note

Name: ID:

Type: Client Demographics

Counselor: Data and time:

Client Information- SDS (CCMH)

What's your gender identity?

Self-Identify gender identity?

What Is your race/ethnically?

Self-identity race/ethnicity?

If you would like to, please further describe your racial, cultural, ethnic, or regional identity

What Is your country of origin? •

Are you an International student? -

Do you consider yourself to be -

Soil-Identify sexual orientation -

Relationship status -

Current academic status •

Other academic status •

Graduate of professional degree program-

Other graduate or professional degree type-

What year are you In your graduate/professional program? -

What is your current GPA? •

Are you registered, with the office for disability services on this campus, as having a documented and diagnosed disability?

If you selected, "Yes" for the previous question, please indicate which category of disability you are registered for-

Did you transfer from another campus/institution to this school? •

Other disability -

What kind of housing do you currently have? -

Other housing -

With whom do you live?

Others living with

Do you participate on an athletic team that competes with other colleges or universities? -

Please indicate your level of involvement in organized extra-curricular activities (e.g., sports, clubs, student government, etc.) -

Please estimate the number of hours per week you are actively involved in organized extra-curricular activities (e.g., sports, clubs, student government, etc.) -

What is the average number of hours you work per week during the school year (paid employment only)? -

Are you a member of ROTC? -

Have you ever served in any branch of the US military (active duty, veteran, National Guard or reserves)?

Did your military experiences include any traumatic or highly stressful experiences which continue to bother you? -

If yes, please describe -

Are you the first generation in your family to attend college? -

How would you describe your financial situation right now -

How would you describe your financial situation while growing up -

Religious or spiritual preference -?

Other religious or spiritual preference -

To what extent does your religious or spiritual preference play an important role in your life? -

Think back over the last two weeks. How many times have you had: five or more drinks* in a row (for males) OR four or more drinks* in a row (for females)?
(* A drink is a bottle of beer, a glass of wine, a wine cooler, a shot glass of liquor, or a mixed drink.) -

Think back over the last two weeks. How many times have you smoked marijuana? -

Attended counseling for mental health concerns -

Taken a prescribed medication for mental health concerns -

Been hospitalized for mental health concerns -

Been hospitalized for mental health concerns (Last time) -

Felt the need to reduce your alcohol or drug use -

Felt the need to reduce your alcohol or drug use (Last time) -

Others have expressed concern about your alcohol or drug use -

Others have expressed concern about your alcohol or drug use (Last time) -

Received treatment for alcohol or drug use -

Received treatment for alcohol or drug use (Last time) -

Purposely injured yourself without suicidal intent (e.g., cutting, hitting, burning, etc.) -

Purposely injured yourself without suicidal intent (e.g., cutting, hitting, burning, etc.) (Last time) -

Seriously considered attempting suicide -

Seriously considered attempting suicide (Last time) -

Made a suicide attempt -

Made a suicide attempt (Last time) -

Considered causing serious physical injury to another person -

Considered causing serious physical injury to another person (Last time) -

Intentionally caused serious physical injury to another -

Intentionally caused serious physical injury to another (Last time) -

Someone had sexual contact with you without your consent (e.g., you were afraid to stop what was happening, passed out, drugged, drunk, incapacitated, asleep, threatened or physically forced) -

Someone had sexual contact with you without your consent (e.g., you were afraid to stop what was happening, passed out, drugged, drunk, incapacitated, asleep, threatened or physically forced) (Last time) -

Experienced harassing, controlling, and/or abusive behavior from another person (e.g., friend, family member, partner, or authority figure) -

Experienced harassing, controlling, and/or abusive behavior from another person (e.g., friend, family member, partner, or authority figure) (Last time) -

Experienced a traumatic event that caused you to feel intense fear, helplessness, or horror -

Experienced a traumatic event that caused you to feel intense fear, helplessness, or horror (Last time) -

If you selected, "Yes" for the previous question, please briefly describe the event(s) -

Other traumatic event -

Please indicate how much you agree with this statement: "I get the emotional help and support I need from my family."

Please indicate how much you agree with this statement: "I get the emotional help and support I need from my social network (e.g., friends & acquaintances)." -