Boston University College of Health & Rehabilitation Sciences: Sargent College
Center for Psychiatric Rehabilitation

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COLLEGE MENTAL HEALTH SERVICES

STUDENT APPLICATION

Please complete all parts of this application, and fax it to Stephanie Cummings at (617) 353-7700. *If you have questions about the application process or services at the Center for Psychiatric Rehabilitation, please refer to the "Living Well" section of our webpage at cpr.bu.edu, or contact Stephanie Cummings at (617) 353-1124 or stephc13@bu.edu.*

PART 1: REQUEST FOR SERVICES

SERVICE: ☐ Niteo ☐ Coaching
SEMESTER: ☐ Fall ☐ Spring ☐ Summer Year: _____

PART 2: CONTACT INFORMATION

Name:

[Last Name] **[First]** **[Middle Initial]**

Home* Address:

[Street] **[Apartment/Suite Number]**

[City/Town] **[State]** **[Zip Code]**

Campus* Address:

[Street] **[Apartment/Suite Number]**

[City/Town] **[State]** **[Zip Code]**

Phone:

[Home] **[Cell]**

Email:

Date of Birth: **Age:**

PART 3: DEMOGRAPHIC INFORMATION

1. What is your gender identity?

☐ Female
☐ Male
☐ Female to male transgender (FTM)
☐ Male to female transgender (MTF)
☐ Other (please specify): _____
☐ Prefer not to answer
☐ I don't know the answer

2. What is your race?

☐ White
☐ Hispanic or Latino
☐ Black or African American
☐ Native American or American Indian
☐ Asian/Pacific Islander
☐ Other (please specify): _____
☐ Prefer not to answer
☐ I don't know the answer

3. What is the highest degree or level of school you have completed?

☐ High School Diploma/GED
☐ Some Undergraduate Coursework
☐ 2-Year College Degree (Associates)
☐ 4-Year College Degree (BA, BS)
☐ Some Graduate Coursework
☐ Graduate Degree (e.g. MA, MFA, PhD, MD)

4. What is your current marital status?

☐ Single/Never Married
☐ Married
☐ Separated
☐ Divorced
☐ Widowed
☐ Prefer not to answer

5. What is your current employment/ volunteer status?

☐ Employed Full-time (40+ hours per week)
☐ Employed Part-time (1-39 hours per week)
☐ Volunteer Full- time (25+ hours a week)
☐ Volunteer Part- time (1-20 hours a week)
☐ Unemployed

6. What is your current religious affiliation?

☐ Christian
☐ Jewish
☐ Buddhist
☐ Muslim
☐ Hindu
☐ Unaffiliated
☐ Other (please specify): _____
☐ Prefer not to answer

7. Military Status:

☐ No, Military Service
☐ Armed Forces – Reserves
☐ Dependent Family Member
☐ Prefer not to answer
☐ Armed Forces – Active Duty
☐ Armed Forces/National Guard
☐ National Guard – not mobilized
☐ Other (please specify): _____

8. Citizenship Status

☐ U.S Citizen by Birth (Native)
☐ Non-resident Allen- Visa type_____Exp. Date:_____
☐ U.S Citizen Naturalized
☐ Permanent Resident

9. What is your sexual identity?

☐ Heterosexual, or straight
☐ Homosexual – gay or lesbian
☐ Bisexual
☐ Other (please specify): _____
☐ Prefer not to answer
☐ I don't know the answer

PART 4: EDUCATION

1. **Name of High School:**

   _____

2. **What is your current enrollment status in college?**

   _____

3. **Name of college you most recently attended/ currently attend:**

   _____

4. **Names of other colleges you have attended:**

   _____

5. **What was the last semester you were enrolled in classes?**

   _____

6. **How many classes/credits did you attempt in your last semester?** _____

7. **How many classes/credits did you complete during that semester?** _____

8. **What is your major/area of study?**

   _____

9. **If you are on a leave of absence, what precipitated your leave?**

   _____

   _____

   _____

10. **Check the programs/assistance/services you used at your college/university:**

    ☐ Individual counseling
    ☐ Group counseling
    ☐ Drug/alcohol education/support programing
    ☐ Campus housing
    ☐ Tutoring in content areas (e.g. engineering)
    ☐ Support from the writing studio
    ☐ Accommodations through the disability services office
    ☐ Academic/life coaching
    ☐ Academic advising
    ☐ Financial aid/scholarships

11. **What was your housing arrangement on/off campus (e.g. lived in a single, had 3 roommates)?**

    _____

12. **If you were tutored in specific content areas, what were they?**

    _____

13. **If you received academic/life coaching, with whom did you meet and how regularly?**

    _____

14. **If you used accommodations through disability services, what were they?**

    _____

PART 5: SELF-ASSESSMENT

Below are lists of skills important for social, academic, and professional wellness. Help us understand your strengths and the challenges you have faced in various settings, check the statements that are true for you.

1. Social Skills

☐ It is difficult for me to ask help from professors, residents, and staff, etc.
☐ Sometimes I feel withdrawn even when I am around people.
☐ I easily get distracted by activity around me.
☐ It's easy for me to misinterpret what others say or do.
☐ Sometimes I feel suspicious of others say or do.
☐ I am lonely at school.
☐ I have no extracurricular activities that I do with others at school**.**

2. Communication Skills

☐ Sometimes I speak so softly no one hears me.
☐ Others have said they don't understand what I am trying to say.
☐ I would rather read directions than listen to them.
☐ Sometimes I don't answer others or respond with only one or two words.
☐ I interrupt others quite a bit.

3. Behavior

☐ I sometimes act without thinking.
☐ I can talk too much or too loudly.
☐ I find it hard to meet deadlines.
☐ It's difficult for me to accept responsibility for me my mistakes.
☐ Sometimes my behaviors seem strange or different to others.
☐ Sometimes I "lose time"
☐ Sometimes I use drugs or alcohol because I feel stressed.
☐ I get physically ill when there are too many demands on me.

4. Relationships

☐ General conversations like, "small talk", are difficult for me.
☐ I usually don't have anything to discuss with others at school before or after class.
☐ I don't know how to respond to people when they make statements I don't like.
☐ I don't know how to explain my health experiences or leave of absence to my friends.
☐ I have very few friends at school.

5. Medication

☐ I get drowsy from my medication(s), which makes it hard to get up/stay awake in class or do homework.
☐ I am thirsty a lot.
☐ My medication blurs my vision.
☐ I am embarrassed to take medications when I am with my classmates/roommates/teammates.
☐ My medication slows my thinking.

PART 5: SELF-ASSESSMENT

6. Thinking/Learning

☐ Sometimes it's difficult for me to concentrate for very long.
☐ It usually takes me a long time to learn/remember new information.
☐ My thoughts easily distract me.
☐ It's difficult to shift my focus from one task to another.
☐ I have trouble making decisions.
☐ I often reach the wrong conclusion.
☐ I am disorganized.
☐ I don't have enough energy to do my work.
☐ Sometimes ideas come to me too fast.
☐ I get restless easily and often.
☐ I start to panic when I'm given deadlines.
☐ Sometimes my mind goes blank when I'm called on in class or during exams.
☐ I have difficulty dealing with unexpected changes.

7. Self-Care

☐ At times, I don't eat very well.
☐ I don't sleep as much as I would like or need.
☐ At times, it's easy to skip some of my daily hygiene tasks.
☐ I don't take my medication as my doctor prescribes.
☐ I don't exercise or do any physical fitness activities.
☐ I can't always predict when I'm going to have an increase in my symptoms.
☐ Sometimes I work long hours and don't take any breaks.
☐ I don't utilize my spiritual practices as much as I would like.
☐ I have a tendency to overuse substances.
☐ I have, at times, been careless/reckless in my sexual relationships.

8. Emotions

☐ Sometimes I worry so much, it's hard to be in school.
☐ I get afraid of people, places or activities.
☐ It's hard for me to hear others express strong feelings.
☐ Sometimes it seems my reactions don't match others'.
☐ I am too afraid to approach my professor(s) or advisor(s)
☐ Even when I get good grades, I'm scared I am going to fail.
☐ Sometimes I feel so good, I take on more than I can handle

9. Treatment Needs

☐ I need to see my doctor, therapist, coach, etc. during the semester.
☐ I need to get to my 12-Step meeting(s) at least _____times per week.
☐ I need to keep in contact with my support team.
☐ I need to stay in touch with my spiritual advisor/priest/rabbi/other.

PART 5: SELF-ASSESSMENT

10. Resource Needs

☐ I don't have enough money for books and supplies.
☐ I can't get a meeting with an academic advisor.
☐ I don't have and would like a doctor, therapist, psychiatrist, or coach
☐ I don't have a place to study or the materials I need to study.
☐ I need specialized housing to accommodate my learning and living.

PART 6: GOALS & INTERESTS

1. What are your academic goals?

2. What are your long-range career goals?

3. What are your long-range personal/life goals?

4. Please identify your interests in the following domains: What are your favorite activities, pastimes, hobbies?

Physical:

Social:

Leisure:

Spiritual:

PART 7: EMERGENCY CONTACT INFORMATION

Name:	
Relationship:	
Address:	
Phone (Primary):	**Phone (Secondary):**
Email:	
Name:	
Relationship:	
Address:	
Phone (Primary):	**Phone (Secondary):**
Email:	

PART 8: PROFESSIONAL SUPPORTS

PRIMARY CARE PHYSICIAN	
Name:	
Medical Facility/Clinic/Program:	
Address:	
Phone (Primary):	**Phone (Secondary):**
Email:	
Approximate length of time working with physician:	

PSYCHIATRIST	
Name:	
Medical Facility/Clinic/Program:	
Address:	
Phone (Primary):	**Phone (Secondary):**
Email:	
Approximate length of time working with psychiatrist:	

PART 8: PROFESSIONAL SUPPORTS

THERAPIST/COUNSELOR	
Name:	
Medical Facility/Clinic/Program:	
Address:	
Phone (Primary):	**Phone (Secondary):**
Email:	
Approximate length of time working with therapist/counselor:	
COLLEGE/UNIVERSITY BEHAVIORAL HEALTH	
Name:	
Medical Facility/Clinic/Program:	
Address:	
Phone (Primary):	**Phone (Secondary):**
Email:	
Approximate length of time working with behavioral health clinician:	

PART 9: REFERENCES

PROFESSIONAL REFERENCE: (University Behavioral Health, Professor, Therapist)	
Name (Primary contact):	
College/University/Counseling Service:	
Address:	
Phone (Primary):	**Phone (Secondary):**
Email:	
PERSONAL REFERENCE: (Family, Peer, Employer)	
Name (Primary contact):	
Company/Organization:	
Address:	
Phone (Primary):	**Phone (Secondary):**
Email:	

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PART 10: AUTHORIZATION FOR TWO-WAY RELEASE OF INFORMATION FOR MEDICAL AND PSYCHIATRIC RECORDS

1. Name of person/facility/agency other than or at Boston University to receive or release information:

_____

2. Information I give permission to release or receive: _____

3. This release will expire on *(specify a date, time period or an event)* _____.
If nothing is specified, it will expire when I am no longer receiving services at Boston University.

I understand that I have a right to withdraw this release at any time. If I withdraw this authorization, I must do so in writing and present it to the address above. I understand that if I pull my release of this information, it will not apply to information that has already been given before I withdrew this permission.

I understand that once the above information is disclosed to a person, facility or agency outside Boston University, the person who receives this information may disclose it again and the information may not be protected by federal or state privacy laws or regulations. I understand that I may choose whether or not to sign this form and that I do not need to sign this form in order to receive rehabilitation and recovery services from Boston University and/or the other person, facility or agency. However, without the ability to share or obtain information, Boston University and/or the other person/agency may not be able to provide effective rehabilitation and recovery services.

_____

Your Signature or Personal Representative's Signature **Date**

_____

Print Name of Signer

If signed by a Personal Representative:
Type of authority (e.g., court appointed, custodial parent) _____

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PART 11: MEDICAL & PSYCHIATRIC INFORMATION FORM

Instructions: Please fax completed form to Stephanie Cummings at (617) 353-7700.

Student's Name:

[Last] **[First]** **[Middle Initial]**

Physician/Psychiatrist's Name:

[Last] **[First]** **[Middle Initial]**

Medical Facility/Clinic/Program:

Date of Last Physical Exam:

Diagnoses:

Please provide full DSM or ICD-10 Code(s):

Initial date of diagnosis: **Date of Last Clinical Contact:**

Does person have any conditions or physical limitations that would prevent him/her from participating in an exercise program?

☐ **Yes** _____ ☐ **No**

1) Weight: _____ lbs. **2) Height: _____** **3) BMI: _____**

Psychiatric Medication(s)

Other Medication(s)

Please List Any Restrictions/Recommendations:

Physician/Psychiatrist's Signature: **Date:**