

# STUDENT HISTORY AND CHECKLIST

Defiance College Counseling Services

Judy Crites, Psychology Practicum Student

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Date: \_\_\_\_\_

## Purpose and Confidentiality

The answers to the following questions are a tool to help the psychology practicum student understand your situation and are also an exercise to allow you to consider your physical symptoms, your level of satisfaction, things that may be causing you distress, your behaviors and emotions, and your current and past experiences.

Your answers to these questions are confidential and will not be contained in any academic, educational, or job placement file. It is both illegal and unethical for a psychology practicum student to break the confidentiality agreement. No information will be disclosed about your treatment or status as a student using the Defiance College Counseling Services without prior written and/or verbal consent.

It is both illegal and unethical for the psychology practicum student to break the confidentiality agreement. No information will be disclosed about your treatment or status as a student using the Defiance College Counseling Services without prior written and/or verbal consent, except under the following circumstances:

- a court order is received,
- there is evidence you are in imminent danger of harming yourself,
- there is evidence you will harm another person,
- there is evidence you are in need of protection,
- there is evidence you are abusing or neglecting a child or vulnerable adult or you give information about someone else who is abusing or neglecting a child or vulnerable adult

If a situation occurs that is life threatening the psychology practicum student will:

- Assure Rescue has been called and the student is transported to a medical facility
- Notify the Dean of Student's office
- Complete crisis report for confidential student file
- Send copy of crisis report to attending physician
- Follow up with any referring sources

## Section I: Physical Symptoms

Please check all of the following that have applied to you in the past two weeks.

- |  |  |
|--|--|
| <input type="checkbox"/> Heart Palpitations/Racing Heart | <input type="checkbox"/> Chronic Pain                    |
| <input type="checkbox"/> Trembling or shaking            | <input type="checkbox"/> Nausea or Abdominal Distress    |
| <input type="checkbox"/> Shortness of Breath             | <input type="checkbox"/> Dizziness or Lightheadedness    |
| <input type="checkbox"/> Feelings of Choking             | <input type="checkbox"/> Numbness or Tingling Sensations |
| <input type="checkbox"/> Chest Pain                      | <input type="checkbox"/> Chills or Hot Flashes           |
| <input type="checkbox"/> Headache                        |  |

Please list any other physical symptoms of concern not included in the above list

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# STUDENT HISTORY AND CHECKLIST

## Section II: Satisfaction Inventory

The following will walk you through some of the general aspects of life as a student. Take time to consider your level of satisfaction in each of these areas.

1. Please indicate your current level of life satisfaction.  
 Not at all       Mild       Moderate       High       Very High
  
2. Please indicate your current level of satisfaction with the college experience.  
 Not at all       Mild       Moderate       High       Very High
  
3. Please indicate your current level of satisfaction with academics.  
 Not at all       Mild       Moderate       High       Very High
  
4. Please indicate your current level of satisfaction with extra-curricular activities or athletics.  
 Not at all       Mild       Moderate       High       Very High
  
5. Please indicate your current level of satisfaction with your social life.  
 Not at all       Mild       Moderate       High       Very High
  
6. Please indicate your current level of satisfaction with your living situation.  
 Not at all       Mild       Moderate       High       Very High
  
7. Please indicate your current level of satisfaction with your family relationships.  
 Not at all       Mild       Moderate       High       Very High
  
8. Please indicate your current level of satisfaction with romantic relationships.  
 Not at all       Mild       Moderate       High       Very High
  
9. Please indicate your current level of satisfaction with relationships with friends.  
 Not at all       Mild       Moderate       High       Very High

# STUDENT HISTORY AND CHECKLIST

## Section III: Distress Inventory

Distress represents feelings of sadness, worry, fear, helplessness, confusion, frustration, or even physical discomfort.

1. Please indicate your current level of general distress.  
 Not at all       Mild       Moderate       High       Very High
2. Please indicate your current level of distress over a significant loss.  
 Not at all       Mild       Moderate       High       Very High
3. Please indicate your current level of distress over a traumatic event.  
 Not at all       Mild       Moderate       High       Very High
4. Please indicate your current level of distress over relationships.  
 Not at all       Mild       Moderate       High       Very High
5. Please indicate your current level of distress concerning sexual identity.  
 Not at all       Mild       Moderate       High       Very High
6. Please indicate your current level of distress concerning academics.  
 Not at all       Mild       Moderate       High       Very High
7. Please indicate your current level of distress concerning finances.  
 Not at all       Mild       Moderate       High       Very High
8. Please indicate your current level of distress concerning career choice.  
 Not at all       Mild       Moderate       High       Very High
9. Please indicate your current level of distress concerning homesickness.  
 Not at all       Mild       Moderate       High       Very High

# STUDENT HISTORY AND CHECKLIST

## Section III: Distress Inventory Continued

10. Please indicate your current level of distress concerning weight/body image.

- Not at all       Mild       Moderate       High       Very High

11. Please indicate your current level of distress concerning sleeping problems.

- Not at all       Mild       Moderate       High       Very High

12. Please indicate your current level of distress concerning alcohol and/or drug use.

- Not at all       Mild       Moderate       High       Very High

13. Please indicate your current level of distress concerning physical/health problems.

- Not at all       Mild       Moderate       High       Very High

14. Please list any other concerns which are causing you distress

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# STUDENT HISTORY AND CHECKLIST

## Section IV: Behaviors and Emotions

Behaviors and emotions can be complex and are the results of your environment, situation, experiences, and genetics. Please consider how you are responding to your life circumstances.

1. I find it difficult to control worrying.

- |                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Never                    | Rarely                   | Sometimes                | Frequently               | Always                   |

2. I avoid social situations

- |                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Never                    | Rarely                   | Sometimes                | Frequently               | Always                   |

3. I feel helpless or out of control.

- |                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Never                    | Rarely                   | Sometimes                | Frequently               | Always                   |

4. I have a lack of interest in activities I usually enjoy.

- |                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Never                    | Rarely                   | Sometimes                | Frequently               | Always                   |

5. I feel detached or estranged from others.

- |                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Never                    | Rarely                   | Sometimes                | Frequently               | Always                   |

6. I feel easily fatigued or experience muscle tension.

- |                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Never                    | Rarely                   | Sometimes                | Frequently               | Always                   |

7. I miss class or other events because of my alcohol/drug use.

- |                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Never                    | Rarely                   | Sometimes                | Frequently               | Always                   |

8. I experience relationship difficulties because of my alcohol/drug use.

- |                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Never                    | Rarely                   | Sometimes                | Frequently               | Always                   |

# STUDENT HISTORY AND CHECKLIST

## Section IV: Behaviors and Emotions Continued

9. I hear voices or see things others do not.

- |                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Never                    | Rarely                   | Sometimes                | Frequently               | Always                   |

10. I feel in a depressed mood.

- |                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Never                    | Rarely                   | Sometimes                | Frequently               | Always                   |

11. I feel worthless.

- |                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Never                    | Rarely                   | Sometimes                | Frequently               | Always                   |

12. I feel guilt.

- |                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Never                    | Rarely                   | Sometimes                | Frequently               | Always                   |

13. I engage in self-destructive behaviors including self-cutting or self-mutilation.

- |                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Never                    | Rarely                   | Sometimes                | Frequently               | Always                   |

14. I worry or think about death.

- |                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Never                    | Rarely                   | Sometimes                | Frequently               | Always                   |

15. Please list any other behaviors or emotions which you consider relevant to your situation.

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# STUDENT HISTORY AND CHECKLIST

## Section V: Experiences

Past and recurring experiences may be the focus of your current concerns or may knowingly or unknowingly be compounding factors to other concerns. (DK: Don't Know)

- 1. Have you ever experienced the loss of a close friend or relative? **Yes No DK**
  
- 2. Have you ever witnessed or experienced a traumatic event including the occurrence or threat of severe physical harm or death? **Yes No DK**
  
- 3. Have you or a family member ever experienced a major illness or accident? **Yes No DK**
  
- 4. Have you ever been a victim of rape? **Yes No DK**
  
- 5. Were you a victim of childhood physical abuse? **Yes No DK**
  
- 6. Were you a victim of childhood sexual abuse/molestation? **Yes No DK**
  
- 7. Have you ever been a victim of adult physical abuse? **Yes No DK**
  
- 8. Have you ever been a victim of adult sexual abuse? **Yes No DK**

9. Please list any other experiences which you consider relevant to your situation.

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## Section VI: Suicidal Thoughts and Actions

- 1. Have you ever considered or made plans to take your own life? **Yes No**
  
- 2. Have you ever attempted suicide? **Yes No**
  
- 3. Have you considered, threatened, or attempted suicide in the past 6 months? **Yes No**