

INFORMATION FOR COUNSELING SERVICES

Rhode Island School of Design

The transition to college life is often a stressful and demanding one. The counseling services at RISD are here to help you if you encounter any emotional problems. In order to assist us please complete the following form. Information provided on this form is strictly confidential and will not be released by the Office of Student Development and Counseling Services to anyone without your written authorization unless required by law. No other College division has access to this information. It cannot affect your standing at school. Your cooperation and accuracy in completing this record will assist us in giving you better care. *If the information requested on this form is not relevant to you, it is not necessary to complete and return this form.* Otherwise, please return the form in the enclosed envelope or to:

Office of Student Development and Counseling Services
Rhode Island School of Design
2 College Street
Providence, RI 02903-2784

Name

Home Telephone

Home Address

Please see reverse

Freshman Transfer Graduate

HISTORY

	Yes	No	
<i>Indicate whether you now have</i>	<input type="checkbox"/>	<input type="checkbox"/>	Seizures/Convulsions
<i>or have had concerns in the areas</i>	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent anxiety/nervousness
<i>listed:</i>	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent depression
	<input type="checkbox"/>	<input type="checkbox"/>	Persistent suicidal thoughts
	<input type="checkbox"/>	<input type="checkbox"/>	Other emotional problems

Psychological/psychiatric treatment

If you answered yes to the above, please briefly describe your history and treatment.

Please indicate other emotional/psychological issues you may have experienced (e.g. substance abuse, eating concerns).

Have you ever been hospitalized for a psychiatric problem? If yes, when and for how long?

Are you presently receiving psychiatric/psychological treatment? Please describe

Are you presently taking psychiatric medication? Please list:

Your psychiatrist's/therapist's name, address and phone number. Your doctor will not be contacted without your permission:

STUDENT SIGNATURE

Signature of Student

Date

PARENTAL PERMISSION *Required only if entrant is under 18 years of age*

I hereby grant permission to the College consulting psychiatrist, Rhode Island School of Design, or his/her authorized

representatives, to furnish such medical care as my son_____ daughter_____ may require, including evaluation,

treatment, etc. This permission is conditioned upon the understanding that in the event of a serious illness or the need for

hospitalization, the college will use all reasonable efforts to contact me. Failure in such efforts, however, should not prevent

the College from providing such emergency treatment as may be necessary for the best interest of the life of _____.

Signature of Parent

Date