

# NEW HAMPSHIRE INSTITUTE OF ART

## Information for Counseling Services

The transition to college life is often a stressful and demanding one. The counseling services provided by the Institute are available to help you with any emotional or psychological needs. In order to assist us, please complete the following form. Information provided on this form is strictly confidential and will not be released without your written authorization unless required by law. No other Institute department has access to this information. It cannot affect your standing at school. Your cooperation and accuracy in completing this record will assist us in meeting your needs. Please return the form in the enclosed envelope to:

**Student Services  
New Hampshire Institute of Art  
148 Concord Street  
Manchester, NH 03104**

Name: \_\_\_\_\_ Home Telephone: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Freshman       Sophomore       Junior       Senior       Other

### **History**

*Please indicate whether you now have or have had concerns in the areas listed below.*

<u>Yes</u>	<u>No</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Seizures/Convulsions
<input type="checkbox"/>	<input type="checkbox"/>	ADD, ADHD
<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Anxiety/Nervousness
<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
<input type="checkbox"/>	<input type="checkbox"/>	Psychological/Psychiatric Treatment

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

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

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

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Are you presently receiving psychiatric/psychological treatment? Please describe.

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Are you presently taking psychiatric medication? Please list.

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

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**Student Signature**

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\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

**Parental/Guardian Permission** *(Required only if student is under 18 years of age.)*

I hereby grant permission to the College Consulting Counseling Service, Bedford Counseling, or the New Hampshire Institute of Art to furnish such medical care as \_\_\_\_\_ (student) 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 NHIA will use all reasonable efforts to contact me. Failure in such efforts, however, should not prevent the NHIA from providing such emergency treatment as may be necessary for the best interest of \_\_\_\_\_ (student).

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date