Global Expeditions Group
YOU ARE YOUR EXPERIENCES

COUNSELING QUESTIONNAIRE

Student Name: _____

Dear Health Care Provider,

Global Expeditions Group is screening your client for participation in one of our programs. This student indicated that counseling has been provided by you within the past year and has given us permission to contact you. We respectfully request your input as we determine if our experience is appropriate for your client at this time.

Global Expeditions Group offers a range of programs from entire semester program spent aboard a vessel at sea, to community service programs in remote international locations. While most trips are only moderately physically challenging, all trips are designed to provide an intense emotional and interpersonal experience. Students are sometimes asked to do things they may not believe they are capable of doing. Part of the safety of our program is our confidence that these activities can be accomplished. Our confidence is based on our 40-year record of safety, the skills of our instructors, and this comprehensive screening process. Screening is designed to pre-determine that our program (a) will meet the needs of the individual while allowing for individual and group safety and (b) is within the scope of their capabilities.

Our classroom is ever shifting and offers a 'wilderness' like setting. The group typically consists of 3-6 staff with 12-24 students from diverse backgrounds. Activities may include sailing, scuba diving, other watersports, community service projects, and hiking/trekking. Skills are taught from a beginner level, and programs are conducted in all weather conditions in varying altitude environments, from sea level to 11,000ft, and even 14,000ft in Peru.

The focus of any Global Expeditions Group program is experiential education. Our goal is to assist each student to recognize and reach beyond self-imposed limits, and to facilitate the group to move from dependence to independence.

While there are wonderful "highs" with any trip, due to the setting, students may be tired, hungry, hot and wet at times. They may confront individual personal fears as well as other frustrations with living in tight quarter with limited personal time and space while having to interact, depend on and trust others. This can create frustration and possible anger while dealing with others within the group who may be experiencing similar emotions. There will be opportunity for processing events through informal group discussions, but we do not endeavor to control the outcome in any prescribed fashion. As stress is created, potential exists that a student may perceive failure or peer rejection. **While our staff members are well qualified for their individual roles within our team, they are NOT psychotherapists.**

Your assistance in helping us determine that this student is capable of having a safe and positive experience is invaluable, and greatly appreciated. Please complete the questionnaire and return it in a timely fashion, as **final acceptance to the program is contingent upon receiving this information.**

Thank you!

RETURN

DIAGNOSIS

Please indicate below your client's diagnosis(es):

☐ ADHD
☐ Autism Spectrum Disorder
☐ Anxiety Disorder
☐ Bipolar Disorders
☐ Depressive Disorder
☐ Disruptive and Conduct Disorder
☐ Eating Disorder
☐ Intellectual Disability
☐ Learning Disability
☐ Obsessive-Compulsive Disorder
☐ Personality Disorder
☐ Schizophrenia Spectrum Disorder
☐ Substance Related Disorder
NOTE: Please indicate the substance(s) and level of problem (use/abuse/dependence) in NOTES section below
☐ Trauma and Stressor Related Disorder
☐ Other:_____

Indicate the recency of each diagnosis.
RECENCY: How recent were the major symptoms?

Diagnosis:_____	**Diagnosis:**_____
☐ <3 Months	☐ <3 Months
☐ 3-6 Months	☐ 3-6 Months
☐ 6-12 Months	☐ 6-12 Months
☐ >1 Year	☐ >1 Year

Indicate the duration of each diagnosis. DURATION: How long has the individual had this condition?

Diagnosis:_____	**Diagnosis:**_____
☐ <3 Months	☐ <3 Months
☐ 3-6 Months	☐ 3-6 Months
☐ 6-12 Months	☐ 6-12 Months
☐ >1 Year	☐ >1 Year

NOTES

TREATMENT/THERAPY

Indicate below any treatment(s) or therapy the apply(ies) to your client CURRENTLY or within the past YEAR.

TYPE OF TREATMENT / THERAPY

☐ Medications (s)
☐ Outpatient Counseling
☐ Day Treatment
☐ Residential Treatment
☐ Hospitalization
☐ Special Treatment (e.g. ECT)
☐ Other (Please Specify)

How long has it been since the last treatment and/or therapy?

Treatment Type: _____
☐ Current ☐ <3 Months ☐ 3-6 Months
☐ 6-12 Months ☐ >1 Year

Treatment Type: _____
☐ Current ☐ <3 Months ☐ 3-6 Months
☐ 6-12 Months ☐ >1 Year

Treatment Type: _____
☐ Current ☐ <3 Months ☐ 3-6 Months
☐ 6-12 Months ☐ >1 Year

MEDICATION STABILITY

Identify Medication(s). How long has each medication been taken?

1. _____	2. _____
☐ <3 Months	☐ <3 Months
☐ 3-6 Months	☐ 3-6 Months
☐ 6-12 Months	☐ 6-12 Months
☐ >1 Year	☐ >1 Year

3. _____	4. _____
☐ <3 Months	☐ <3 Months
☐ 3-6 Months	☐ 3-6 Months
☐ 6-12 Months	☐ 6-12 Months
☐ >1 Year	☐ >1 Year

RETURN

SYMPTOMS (Observed/Reported)

Indicate the symptoms that your client has manifested within the past 6 MONTHS.

LIST 1

- ☐ Annoying
- ☐ Argumentative
- ☐ Avoidance (E.G. People, Places, Activities)
- ☐ Binge Eating
- ☐ Blames Others
- ☐ Controlling
- ☐ Deceitful
- ☐ Defiance
- ☐ Difficulty Concentrating
- ☐ Difficulty Organizing
- ☐ Diminished Appetite
- ☐ Disturbed Body Perception
- ☐ Easily Distracted
- ☐ Excessive Exercise
- ☐ Fasting
- ☐ Fatigue
- ☐ Feelings of Guilt or Worthlessness
- ☐ Flight of Ideas
- ☐ Hyperactive
- ☐ Hyper-Vigilance
- ☐ Immature for Age
- ☐ Inattentive
- ☐ Insomnia
- ☐ Interrupts
- ☐ Irritability
- ☐ Labile
- ☐ Lack of Empathy
- ☐ Little or No Motivation
- ☐ Loss of Temper
- ☐ Low Self Esteem
- ☐ Memory Loss
- ☐ Motor Restless
- ☐ Oppositional
- ☐ Perfectionism
- ☐ Poor Social Skills
- ☐ Restricted Affect
- ☐ Sadness
- ☐ Social/Occupational Dysfunction
- ☐ Suspiciousness
- ☐ Talks Excessively
- ☐ Tics
- ☐ Unable to Follow Instructions
- ☐ Use of Laxatives, Diuretics, Appetite Suppressants
- ☐ Worry

LIST 2

- ☐ Accident Prone
- ☐ Aggression
- ☐ Anxiety
- ☐ Body Weight Less then 85% of Normal
- ☐ Depression
- ☐ Destruction of Property
- ☐ Detachment
- ☐ Disorganized Speech
- ☐ Impaired Communication
  (e.g. delay/lack of spoken language, repetitive or idiosyncratic Language)
- ☐ Impaired Social Interaction
  (e.g. no eye contact, blank facial expression)
- ☐ Impulsivity
- ☐ Inflated Self Esteem or Grandiosity
- ☐ Irrational Fears (Death, Los of Control)
- ☐ Low Frustration Tolerance
- ☐ Mania
- ☐ Perceptual or Cognitive Distortion
- ☐ Promiscuity
- ☐ Purging
- ☐ Repetitive Behavior (Hand Washing, Counting)
- ☐ Repetitive/Stereotypical Behaviors
  (e.g. inflexible non-functional routine or rituals, stereotype/repetitive motor mannerisms)
- ☐ Restrictive Eating
- ☐ Serious Violation of Rules (truancy, run away)
- ☐ Significant Weight Change
- ☐ Somatic Complaints
- ☐ Theft

LIST 3

- ☐ Catatonic or Disorganized Behavior
- ☐ Delusions
- ☐ Dissociation
- ☐ Feeling Event is Recurring
- ☐ Flashbacks
- ☐ Hallucinations
- ☐ Mood Swings
- ☐ Recurrent, Persistent Intrusive Thoughts
- ☐ Self Harm
- ☐ Thoughts of Death
- ☐ Use of Weapons
- ☐ Violence

OTHER

RETURN

ADDITIONAL INFORMTIAON

Please list your client's greatest strengths as they relate to a Global Expeditions Group experience.

Please list any coping skills your client utilizes.

Please give us a sense of how your client approaches self-care and asking for support.

Please share with us any tips you have for helping this client be successful during a Global Expeditions Group experience.

Please provide any other information you feel should be considered while screening your client, or any other recommendations for our staff while working with your client.

RETURN

WHODAS 2.0 SCORE

Cognition _____ Self-care _____ Life Activities _____

Mobility _____ Getting along _____ Participation _____

EHODAS 2.0 Summary Score _____

GAF Score (if preferred) _____

SIGNIFICANT LIFE EVENTS

Indicate any of the following that your client has experienced within **the past six months**

Health
- ☐ Serious Accident/Injury
- ☐ Serious Illness

Occupational
- ☐ Job Difficulty
- ☐ Job Loss

Personal
- ☐ Bankruptcy
- ☐ Frequent Moves
- ☐ Fire/Natural Disaster
- ☐ Neglect
- ☐ Sexual Abuse

Interpersonal/Family
- ☐ Adoption
- ☐ Foster Care Placement
- ☐ Relationship Loss
- ☐ Separation
- ☐ Divorce
- ☐ Death

Legal
- ☐ Legal Problems
- ☐ Probation
- ☐ Incarceration

School
- ☐ School Problems
- ☐ Academic Failure
- ☐ Suspension/Expulsion

CLIENT INFORMATION

Is this client currently in counseling with you? ☐ Yes ☐ No Date of last session? _____

If "Yes," what is the frequency of sessions? _____

If "No", why was therapy terminated? _____

To your knowledge, does the client want to attend a Global Expeditions program, or is he/she being strongly encouraged by someone else? _____

THERAPIST INFORMATION

Company Name _____ Therapist Name: _____

Therapist Signature: _____ Discipline: _____

Tel # _____ Email _____

May we contact you with questions? ☐ Yes ☐ No

If "Yes" what is the preferred method of contact? _____

Statement of confidentiality: All information provided to Global Expeditions Group will remain confidential and not be released to any outside organization or agency without a written release from your client if 18, or a parent or guardian if under 18.

RETURN