

STUDENT PSYCHOLOGICAL SERVICES

STUDENT HEALTH SERVICES



Hello, and thank you for coming to Student Psychological Services.

All regularly scheduled SPS appointments are currently filled, but we would still like to meet your needs as best we can. Please fill out one of our “wait list” packet of forms. If an appointment becomes available, the therapist will call you immediately.

If you are in a crisis situation or if your problem is very urgent, please call the Sonoma County Crisis Line at 576-8181. You may use our Student Health Services phone to do so. Please ask the receptionist for a private place from which to call.

We provide daily drop-in services that do not require an advance appointment. Times are listed below, and drop-in is on a first come/first serve basis.

Santa Rosa campus: Daily @ 2pm
(Please arrive at 1:30 to fill out paperwork)

Petaluma campus: Tuesdays & Thursdays @ 2 pm
(Please arrive at 1:30 to fill out paperwork)

If you are seeking standard or low-fee therapy in the community, or have medical insurance with mental health coverage, please refer to the SPS REFERRAL LIST attached to this letter. We have included information on some 24-hour hotlines, as well as agencies that provide mental health services in the community, some of them low-fee, bilingual, and/or accept MediCare/MediCal clients.

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SPS Wait List Form

Student Psychological Services has a waiting list at this time. Usually the wait is only a few weeks. If you would like to make an appointment, please fill out this form COMPLETELY, and return it to the Student Health Services staff. A therapist will contact you within five working days.

If you cannot be contacted by telephone, do not wish that a message be left for you on your answering machine, or feel that the problem is too urgent to wait for five days, please complete this form, AND come to SPS Drop-In, available daily at 2PM at the Santa Rosa campus. Drop-in is also available on Tuesday and Friday at 2:00PM at the Petaluma campus.

Thank you for your help and patience

Today's Date: _____ SSN: _____ Birthdate: _____

Name: _____

Phone: _____
(home) (work) (cell/pager)

Is it okay to leave a message? _____ Yes _____ No

Have you been seen by an SPS therapist before? _____ Yes _____ No

If yes: When last seen? _____ Therapist's name _____

Is a therapist in the community currently seeing you? _____ Yes _____ No

List at least three two-hour time blocks (day or evening) you will be available during the next two weeks to receive calls:

- 1) _____
- 2) _____
- 3) _____

Please list the type of therapy you are interested in receiving:

_____ Individual _____ Couple _____ Family _____ Consultation, or referral

Please tell us how urgent you feel your need is for therapy.

___ Very urgent ___ Somewhat urgent ___ Not very urgent ___ Not urgent at all

Please describe the issue that brings you to therapy as specifically as possible:

Can you go to the Petaluma Campus for therapy? _____ Yes _____ No

Can you go to the Santa Rosa Campus for therapy? _____ Yes _____ No

**Please block out the times below that
ABSOLUTELY DO NOT WORK FOR YOU
to have an appointment with a therapist**

Time	Monday	Tuesday	Wednesday	Thursday	Friday
8:00 – 8:30					
8:30 – 9:00					
9:00 – 9:30					
9:30 – 10:00					
10:00 – 10:30					
10:30 – 11:00					
11:00 – 11:30					
11:30 – 12:00					
12:00 – 12:30					
12:30 – 1:00					
1:00 – 1:30					
1:30 – 2:00					
2:00 – 2:30					
2:30 – 3:00					
3:00 – 3:30					
3:30 – 4:00					
4:00 – 4:30					
4:30 – 5:00					
5:00 – 5:30					
5:30 – 6:00					
6:00 – 6:30					
6:30 – 7:00					

Information and Agreement

Welcome to SPS!

Please read and fill out the following information, and sign the agreement at the bottom of the second page.

Printed Name _____ Date of Birth: _____ Age: _____ Sex: F/M

Phone: Home: _____ Work: _____ Cell/Pager: _____

Best time(s) to reach you: _____

Home Address: _____

Mailing Address (if different): _____

Is it OK to leave a message on/at your home phone?(circle) YES NO

If "NO" please indicate alternative means of contacting you: _____

Emergency Contact: _____ Phone: _____

Current Employment: _____ SSN# _____

Referred by: _____ Relationship: _____

If not referred, how did you find out about SPS? Friend/student Student Health Services SRJC Academic Counselor SRJC faculty/staff Other

Credits you are enrolled in this quarter: _____

Current Physician: _____ Phone: _____

Are you currently in therapy (individual or other) with another therapist? YES NO

Have you been in therapy before? YES NO

When and for how long? _____

Have you been seen by a Student Psychological Services therapist before? YES NO

If yes: Name of Therapist you saw: _____

Year and Quarter you saw therapist: _____

Your Current living situation: (please check all that apply to you):

alone single married divorced domestic partner with partner with children with family/parents Partner's name: Your Ethnicity:

Do you have medical insurance? YES NO

MediCal MediCare Kaiser Other: _____

If you have medical insurance, do you have mental health coverage? YES NO

SPS provides short and some longer-term therapy for individuals, couples and groups at the SRJC Santa Rosa and Petaluma campuses.

- Medication Evaluation and Psychological Assessment are also available on an as needed basis.
- To be eligible to be seen at SPS you must be officially registered as a SRJC student.
- Therapists at SRJC SPS are unlicensed PhD (Doctoral) and MFT/MSW (Master's) level interns who are supervised by licensed mental health professionals.

Therapy: Participation in therapy can offer clients many benefits, including improved state of mind and mood, increased life skills, more satisfying relationships, and even enhanced concentration, performance and physical health. Research has shown that therapy works best when you and your therapist have an honest, mutually respectful, cooperative relationship, and you and your therapist will work to identify your goal(s) and design a program of psychological healing that takes your individual needs and situation into account. Together you plan your treatment, working to understand the nature, impact and source of any psychological obstacles to your mood or well-being, and to develop skills, strategies and more effective ways of dealing with any stressful life situations, habits, and conditions which interfere with your well-being. The focus is on an effective and positive wellness program that works for you. Using these services successfully requires your active participation, both in sessions and on homework. Therapy can also involve some risk. Because of the nature of what is addressed, difficult or uncomfortable feelings may come up, and sometimes clients can experience a sense of "getting worse" as they address these painful issues, before they experience feeling "better." There is no foolproof method to know in advance what may occur for you in the process, and no absolute guarantees about outcome. You are encouraged to bring up any questions or concerns about your therapy whenever they arise. The benefits and risks of therapeutic treatment will be discussed in the course of your therapy, as well as any alternative treatments, as the need arises.

Length of Therapy: The length of therapy will be decided by you and your therapist together, keeping in mind that we have a large number of students to serve, and that SPS works on an academic calendar with interns on ten-month commitments. If you or your therapist feels that longer-term therapy would be most helpful, we will be happy to give you referrals to therapists in the community.

Confidentiality: All information between the student and SPS is strictly confidential unless:

1. The student authorizes release of information with a signature. (See also Notice of Privacy Practices).
2. The student presents a physical danger to self or others (required by law).
3. There is suspicion of child, elder or dependent adult abuse (required by law).

Litigation Limitation: Due to the nature of the therapeutic process and that fact that it often involves making full disclosure with regard to many confidential matters, it is agreed that should there be legal proceedings (such as but not limited to: divorce/custody disputes, injuries, lawsuits) neither you, nor your attorney(s), nor anyone else acting on your behalf, will call SPS to request testimony in court or at any other proceeding, nor will a disclosure of therapy records be requested.

Ethical Standards: Therapy *never* involves sexual or business relationships, or any other dual relationship that could be exploitative of the client, or might impair the therapist's 1) professional objectivity, 2) clinical judgment, or 3) therapeutic effectiveness.

Cancellations: Due to demand for Psychological Services, you must attend your scheduled appointments, or cancel as soon as possible but *no later than 48 hours in advance by calling SPS (527-4445)*. If you fail to attend an appointment and do not cancel you may forfeit future appointments.

I have read and understand the above information given to me at the SPS, and agree to engage in treatment.

Signature of Client

Date: _____

Signature of Therapist

(Printed Name)

Date: _____



STUDENT HEALTH SERVICES

PROVIDER NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY BEFORE SIGNING

OUR LEGAL DUTY:

We are required by law to protect the privacy of your information, provide this notice about our information practices, follow the information practices that are described in this notice, and obtain your acknowledgment of receipt of this notice.

INDIVIDUAL RIGHTS:

In most cases, you have the right to look at or get a copy of health information about you that we use to make decisions about your care. You also have the right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment or related administrative purposes and other than when you explicitly authorized it. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

USES AND DISCLOSURES OF HEALTH INFORMATION:

Student Health Services staff include District employed support staff and medical clinicians, District contracted physicians, District contracted mental health providers, and community health clinic providers with whom we have a Memorandum of Understanding in place to offer clinical services on site. In the interest of providing continuity of care, information may be shared among these providers and with other providers to whom you are referred, only to the extent that it ensures appropriate treatment. We may use health information about you among these providers for administrative purposes, to evaluate the quality of care that you receive or to obtain payment for treatment received and not covered by your student health fee. Information may be shared by paper mail, fax, or other confidential methods. At no time is this information shared with other college administrators, faculty or staff without your specific written authorization.

We may use, disclose or allow access to identifiable health information about you without your authorization for several reasons. Subject to certain requirements, we may give out health information without your authorization between the following: District employees of Student Health Services and contracted providers within Student Health Services; medical record database management entities with whom Student Health Services holds a contract; for training, public health; or auditing purposes; for research studies; and for emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. We may use or disclose your protected health information as necessary to contact you or remind you of your appointment. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization by writing a revocation statement to the Director of Student Health Services (address below) to stop any future uses and disclosures.

We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

COMPLAINTS:

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You also may send a written complaint to Santa Rosa Junior College's Vice President of Student Services. The person listed below can provide you with the appropriate address upon request.

*If you have any questions or complaints, please contact:
Susan Quinn, Director SRJC, Student Health Services 1501, Mendocino Avenue
Santa Rosa, CA 95401, 707.527.4445*

Verbal acknowledgement of having received of SRJC Student Health Services Provider Notice of Privacy Rights will be recorded by SHS staff in Electronic Practice Management.

Client Concerns and History

The following information will help in a holistic assessment and treatment of your current needs. Please fill out the following information briefly, but mentioning anything you think is relevant (using the back as necessary). All information is covered by our confidentiality policy.

Name: _____ Today's Date: _____

Describe your reasons for seeking therapy at this time: _____

Describe your current concerns and symptoms: _____

Check the answer which best applies to you:

My current concerns and symptoms are:

- ___ the continuation of a long-standing condition
___ a recent worsening of an on-going condition
___ the reoccurrence of a previous condition
___ significantly different from any previous condition
___ the first occurrence of any condition

My current symptoms developed:

- ___ suddenly (over less than four weeks)
___ gradually (over one to several months)
___ very gradually (over one to several years)

Education: _____ Current Work/School Status: _____

Employer: _____ Type of Position: _____

School Program/Area of Study: _____

General Health Status: circle: Excellent Good Fair Poor

Medical History: Please list major illnesses, conditions, injuries or surgeries, with dates of diagnosis and treatment.

Current Medications and dosages:

Table with 4 columns: Medication, Dosage, Date Started, Prescribing Physician

Any past Psychiatric/Psychotropic Medications and dosages:

Table with 4 columns: Medication, Dosage, Date Started, Prescribing Physician

Please circle if you experience these regularly: Headache Back Pain Stomachaches Mood changes

How many hours do you sleep per night? _____ Does it feel adequate? YES NO
Difficulties with sleep? YES NO Has this changed recently? YES NO

Do you eat regular meals each day? YES NO How many? ___ Are you concerned about your diet/weight? YES NO

Do you eat a balanced diet including: please check ___ Water ___ Vegetables ___ Protein
___ Dairy ___ Grains/Carb ___ Fats

Are there certain foods you never eat? _____

Do you have any allergies? _____

Please Check if, Tobacco _____ Marijuana _____ Alcohol _____
and detail Heroin _____ Methamphetamine _____
how much: other Street Drugs (name) _____
 Soda _____ Desserts _____ Caffeine (Tea /Coffee) _____

Exercise : *circle* Walk Hike Run Bike Ski Other: _____
How much do you exercise per week? _____

Activity: *circle* Read Listen to music Sew Play Instrument Computer
Carpentry TV Other(s): _____

How much activity/leisure per week? _____
Do you tend to relax better: Alone With others
What do you find most relaxing? _____

How does your current state of mind affect the following (*circle*):

Physical Functioning:	NONE	SOME	A LOT	Concentration:	NONE	SOME	A LOT
Work/School Functioning:	NONE	SOME	A LOT	Relationships:	NONE	SOME	A LOT

Indicate if you engage in the following regularly: *check*

<input type="checkbox"/> Time with family	<input type="checkbox"/> Cultural activities (movies, plays, readings etc)
<input type="checkbox"/> Time with children	<input type="checkbox"/> Community activities (school /town events, volunteering)
<input type="checkbox"/> Leisure activities	<input type="checkbox"/> Spiritual practice
<input type="checkbox"/> Vacations	<input type="checkbox"/> Spiritual/religious community
<input type="checkbox"/> Social time with friends	<input type="checkbox"/> Support activities/community
<input type="checkbox"/> Time with pets	<input type="checkbox"/> Other: _____

Satisfaction level in your work: <i>circle</i> :	Excellent	Good	Fair	Poor
Satisfaction level in your primary relationship: <i>circle</i> :	Excellent	Good	Fair	Poor
Satisfaction level in your parenting/family: <i>circle</i> :	Excellent	Good	Fair	Poor

What is your general mood lately? _____
examples: calm anxious worried sad content angry irritated despairing other

Do you have thoughts of hurting yourself or others? Yes No If yes, please describe:

Have you in the past had thoughts of hurting yourself or others? Yes No If yes, please describe:

What recent life changes/losses have you experienced? _____

Please indicate any significant prenatal and/or developmental history: _____

Have you experienced emotional and/or physical trauma? Please describe, with dates:

Please describe any family history of psychiatric illness in your immediate/extended family: _____

Please describe your work/school history and current situation: _____

Please describe your relationship with your family of origin. Include relevant life events, as well as any parental substance use/illness issues: _____

Have you been in previous psychotherapy, or been hospitalized in a psychiatric facility? Please describe, with dates:

Please describe your current family situation and relationship history: _____

Please describe your current support system (family, friends, organizations, self): _____

Please describe what you see as your strengths and limitations:

Strengths

Limitations

Please describe your goals for your work in therapy:

Please mention anything else you would like to add:

INSTRUCTIONS:

On the next page is a list of problems people sometimes have. Please read each one carefully, and blacken the circle that best describes HOW MUCH THAT PROBLEM HAS DISTRESSED OR BOTHERED YOU DURING THE PAST 7 DAYS INCLUDING TODAY. Blacken the circle for only one number for each problem and do not skip any items. If you change your mind, erase your first mark carefully. Read the example before beginning, and if you have any questions please ask them now.

	NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY	EXAMPLE
1	①	①	②	③	④	HOW MUCH WERE YOU DISTRESSED BY: Bodyaches

	NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY	HOW MUCH WERE YOU DISTRESSED BY:
1	①	①	②	③	④	Nervousness or shakiness inside
2	①	①	②	③	④	Faintness or dizziness
3	①	①	②	③	④	The idea that someone else can control your thoughts
4	①	①	②	③	④	Feeling others are to blame for most of your troubles
5	①	①	②	③	④	Trouble remembering things
6	①	①	②	③	④	Feeling easily annoyed or irritated
7	①	①	②	③	④	Pains in the heart or chest
8	①	①	②	③	④	Feeling afraid in open spaces or on the streets
9	①	①	②	③	④	Thoughts of ending your life
10	①	①	②	③	④	Feeling that most people cannot be trusted
11	①	①	②	③	④	Poor appetite
12	①	①	②	③	④	Suddenly scared for no reason
13	①	①	②	③	④	Temper outbursts that you could not control
14	①	①	②	③	④	Feeling lonely even when you are with people
15	①	①	②	③	④	Feeling blocked in getting things done
16	①	①	②	③	④	Feeling lonely
17	①	①	②	③	④	Feeling blue
18	①	①	②	③	④	Feeling no interest in things
19	①	①	②	③	④	Feeling fearful
20	①	①	②	③	④	Your feelings being easily hurt
21	①	①	②	③	④	Feeling that people are unfriendly or dislike you
22	①	①	②	③	④	Feeling inferior to others
23	①	①	②	③	④	Nausea or upset stomach
24	①	①	②	③	④	Feeling that you are watched or talked about by others
25	①	①	②	③	④	Trouble falling asleep
26	①	①	②	③	④	Having to check and double-check what you do
27	①	①	②	③	④	Difficulty making decisions
28	①	①	②	③	④	Feeling afraid to travel on buses, subways, or trains
29	①	①	②	③	④	Trouble getting your breath
30	①	①	②	③	④	Hot or cold spells
31	①	①	②	③	④	Having to avoid certain things, places, or activities because they frighten you
32	①	①	②	③	④	Your mind going blank
33	①	①	②	③	④	Numbness or tingling in parts of your body
34	①	①	②	③	④	The idea that you should be punished for your sins
35	①	①	②	③	④	Feeling hopeless about the future
36	①	①	②	③	④	Trouble concentrating
37	①	①	②	③	④	Feeling weak in parts of your body
38	①	①	②	③	④	Feeling tense or keyed up
39	①	①	②	③	④	Thoughts of death or dying
40	①	①	②	③	④	Having urges to beat, injure, or harm someone
41	①	①	②	③	④	Having urges to break or smash things
42	①	①	②	③	④	Feeling very self-conscious with others
43	①	①	②	③	④	Feeling uneasy in crowds, such as shopping or at a movie
44	①	①	②	③	④	Never feeling close to another person
45	①	①	②	③	④	Spells of terror or panic
46	①	①	②	③	④	Getting into frequent arguments
47	①	①	②	③	④	Feeling nervous when you are left alone
48	①	①	②	③	④	Others not giving you proper credit for your achievements
49	①	①	②	③	④	Feeling so restless you couldn't sit still
50	①	①	②	③	④	Feelings of worthlessness
51	①	①	②	③	④	Feeling that people will take advantage or you if you let them
52	①	①	②	③	④	Feelings of guilt
53	①	①	②	③	④	The idea that something is wrong with your mind