

### 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# \_\_\_\_\_

Your Current living situation: (please check all that apply to you):  
\_\_\_\_\_ alone \_\_\_\_\_ single \_\_\_\_\_ married \_\_\_\_\_ divorced \_\_\_\_\_ domestic partner  
\_\_\_\_\_ with partner  
\_\_\_\_\_ with children Partner's name: \_\_\_\_\_  
\_\_\_\_\_ with family/parents Your Ethnicity: \_\_\_\_\_

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: \_\_\_\_\_

Do you have medical insurance with mental health coverage? YES NO  
\_\_\_\_\_ MediCal \_\_\_\_\_ Medicare \_\_\_\_\_ Kaiser \_\_\_\_\_ Other: \_\_\_\_\_

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: \_\_\_\_\_

- 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 presets 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*

## ACKNOWLEDGEMENT OF RECEIPT OF "NOTICE OF PRIVACY PRACTICES":

**By signing and dating this form you acknowledge having read, understood, and agreed to contents of SRJC Student Health Services Provider Notice of Privacy Rights.**

**Printed Name:** \_\_\_\_\_

**SSN:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

STUDENT HEALTH SERVICES

### 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:

<i>Medication</i>	<i>Dosage</i>	<i>Date Started</i>	<i>Prescribing Physician</i>

Any *past* Psychiatric/Psychotropic Medications and dosages:

<i>Medication</i>	<i>Dosage</i>	<i>Date Started</i>	<i>Prescribing Physician</i>

*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, and detail how much:  
\_\_\_ Tobacco \_\_\_\_\_ \_\_\_ Marijuana \_\_\_\_\_ \_\_\_ Alcohol \_\_\_\_\_  
\_\_\_ Heroin \_\_\_\_\_ \_\_\_ Methamphetamine \_\_\_\_\_  
\_\_\_ 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*

\_\_\_ Time with family \_\_\_ Cultural activities (movies, plays, readings etc)  
\_\_\_ Time with children \_\_\_ Community activities (school /town events, volunteering)  
\_\_\_ Leisure activities \_\_\_ Spiritual practice  
\_\_\_ Vacations \_\_\_ Spiritual/religious community  
\_\_\_ Social time with friends \_\_\_ Support activities/community  
\_\_\_ Time with pets \_\_\_ Other: \_\_\_\_\_

Satisfaction level in your work: *circle*: Excellent Good Fair Poor

Satisfaction level in your primary relationship: *circle*: Excellent Good Fair Poor

Satisfaction level in your parenting/family: *circle*: 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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	HOW MUCH WERE YOU DISTRESSED BY: Bodyaches

---

	NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY	
						<b>HOW MUCH WERE YOU DISTRESSED BY:</b>
1	⓪	①	②	③	④	Nervousness or shakiness inside
2	⓪	①	②	③	④	Faintness or dizziness
3	⓪	①	②	③	④	The idea that someone else can control your thoughts
4	⓪	①	②	③	④	Feeling others are to blame for most of your troubles
5	⓪	①	②	③	④	Trouble remembering things
6	⓪	①	②	③	④	Feeling easily annoyed or irritated
7	⓪	①	②	③	④	Pains in the heart or chest
8	⓪	①	②	③	④	Feeling afraid in open spaces or on the streets
9	⓪	①	②	③	④	Thoughts of ending your life
10	⓪	①	②	③	④	Feeling that most people cannot be trusted
11	⓪	①	②	③	④	Poor appetite
12	⓪	①	②	③	④	Suddenly scared for no reason
13	⓪	①	②	③	④	Temper outbursts that you could not control
14	⓪	①	②	③	④	Feeling lonely even when you are with people
15	⓪	①	②	③	④	Feeling blocked in getting things done
16	⓪	①	②	③	④	Feeling lonely
17	⓪	①	②	③	④	Feeling blue
18	⓪	①	②	③	④	Feeling no interest in things
19	⓪	①	②	③	④	Feeling fearful
20	⓪	①	②	③	④	Your feelings being easily hurt
21	⓪	①	②	③	④	Feeling that people are unfriendly or dislike you
22	⓪	①	②	③	④	Feeling inferior to others
23	⓪	①	②	③	④	Nausea or upset stomach
24	⓪	①	②	③	④	Feeling that you are watched or talked about by others
25	⓪	①	②	③	④	Trouble falling asleep
26	⓪	①	②	③	④	Having to check and double-check what you do
27	⓪	①	②	③	④	Difficulty making decisions
28	⓪	①	②	③	④	Feeling afraid to travel on buses, subways, or trains
29	⓪	①	②	③	④	Trouble getting your breath
30	⓪	①	②	③	④	Hot or cold spells
31	⓪	①	②	③	④	Having to avoid certain things, places, or activities because they frighten you
32	⓪	①	②	③	④	Your mind going blank
33	⓪	①	②	③	④	Numbness or tingling in parts of your body
34	⓪	①	②	③	④	The idea that you should be punished for your sins
35	⓪	①	②	③	④	Feeling hopeless about the future
36	⓪	①	②	③	④	Trouble concentrating
37	⓪	①	②	③	④	Feeling weak in parts of your body
38	⓪	①	②	③	④	Feeling tense or keyed up
39	⓪	①	②	③	④	Thoughts of death or dying
40	⓪	①	②	③	④	Having urges to beat, injure, or harm someone
41	⓪	①	②	③	④	Having urges to break or smash things
42	⓪	①	②	③	④	Feeling very self-conscious with others
43	⓪	①	②	③	④	Feeling uneasy in crowds, such as shopping or at a movie
44	⓪	①	②	③	④	Never feeling close to another person
45	⓪	①	②	③	④	Spells of terror or panic
46	⓪	①	②	③	④	Getting into frequent arguments
47	⓪	①	②	③	④	Feeling nervous when you are left alone
48	⓪	①	②	③	④	Others not giving you proper credit for your achievements
49	⓪	①	②	③	④	Feeling so restless you couldn't sit still
50	⓪	①	②	③	④	Feelings of worthlessness
51	⓪	①	②	③	④	Feeling that people will take advantage of you if you let them
52	⓪	①	②	③	④	Feelings of guilt
53	⓪	①	②	③	④	The idea that something is wrong with your mind