State Center Community College District

Request for Psychological Services

First Name: _____ Last Name: _____ Date: _____

Student ID#: _____ DOB: _____ Age: _____

Phone (primary): _____ **OK to call?** YES NO **OK to leave a message?** YES NO

Phone (secondary): _____ **OK to call?** YES NO **OK to leave a message?** YES NO

Email Address: _____ **OK to email?** YES NO

Correspondence Address: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: _____ Initial here to give permission to contact: _____

LIMITED CONFIDENTIALITY

Information shared with psychological services staff will be kept confidential except within a few specific circumstances. Psychological staff are mandated reporters. Information related to harm to self or others, minor, elder, or dependent adult abuse/neglect will be shared with the proper authorities.

Are you thinking of **harming yourself**? YES NO

Are you thinking of **harming or killing another person**? YES NO

Are you having **suicidal thoughts**? YES NO

GENDER: *(male, female, gender-fluid, transgender, etc.)*

_____

_____

_____

ETHNICITY: *(African-American, Asian, Caucasian, etc.)*

_____

_____

_____

MARITAL STATUS:

❑ Single
❑ Dating Someone
❑ Live With Significant Other
❑ Married
❑ Separated
❑ Divorced
❑ Widowed

Therapy appointments are 45-50 minutes long and start at the top of the hour. We have an easier time scheduling appointments for students with better availability. Please keep this in mind when listing your availability.

PLEASE LIST ALL YOUR AVAILABLE TIMES BETWEEN 8AM to 4PM

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY

Do you have insurance?

❑ No ❑ Yes, not sure which ❑ Medi-Cal ❑ Cal-Viva ❑ Kaiser Permanente ❑ Blue Shield ❑ Anthem Blue Cross ❑ Name: _____

Who referred you:

❑ Instructor ❑ Friend ❑ Self ❑ Family ❑ Counselor ❑ Coordinator

❑ Dean ❑ Vice President ❑ Nurse ❑ District Police ❑ Website Name: _____

Check issues you are now having or have experienced within the last two weeks		
EMOTIONAL CONCERNS ❑ Sad or depressed ❑ Feelings of worthlessness ❑ Feelings of hopelessness ❑ Tired, lack of energy ❑ Decrease in drive or motivation ❑ Isolation or feelings of loneliness ❑ Irritability, hostility, anger ❑ Relationship concerns **THINKING CONCERNS** ❑ Problems remembering ❑ Difficulty making decisions ❑ Hearing voices or seeing things that others don't ❑ Told my behavior is odd or eccentric ❑ Poor concentration or focus ❑ Thoughts I'd be better off dead	**STRESS or ANXIETY CONCERNS** ❑ Fear or anxiousness ❑ Panic attacks ❑ Stress, worry ❑ Test anxiety ❑ Persistent intrusive thoughts ❑ Restlessness or feeling keyed up or on edge ❑ Shyness/discomfort in social situations ❑ Self-harming ❑ Substance use ❑ Eating disorder	**OTHER CONCERNS** ❑ Spiritual issues ❑ Gender identity issues ❑ Sexual orientation questions ❑ Concerns about family ❑ Adjustments to college ❑ Cultural conflict or prejudice ❑ Financial problems ❑ Legal problems ❑ Grief / loss ❑ **OTHER** (specify): _____ _____ _____ _____

Briefly describe your reasons for seeking therapy at this time:

_____

_____

_____

Rate your current level of distress: MINIMAL MILD MODERATE SEVERE

Have you ever been hospitalized for Psychiatric reasons in the past? YES NO

If "YES", please complete the information below regarding your hospitalization(s)

When were you hospitalized? (Month and year if possible)	Where were you hospitalized?	How long were you hospitalized?	Why were you hospitalized?

Signature of Understanding and Request for Services

By signing below, I acknowledge that I have read and understand the clinician's role as a **mandated reporter** and the **limits of confidentiality** as outlined on page 1 of this form. I also acknowledge that I understand that the purpose of the mental health screening appointment is to **determine whether campus services OR community services are most appropriate for me** based on the clinician's judgment of my current treatment needs. I understand that the brief screening appointments are only **15-20 minutes long**, and that if I do not **call within 24 hours to reschedule, are late, or do not attend my scheduled mental health screening appointment**, **I will be required to resubmit a psychological services request and screening form.**

I am requesting campus psychological services at:

❑ Fresno City College ❑ Reedley College ❑ Clovis Community College ❑ Madera Community College

_____ _____

Student Signature Date

Informed Consent for Therapeutic Services

Please Read Carefully Before Signing

Name: _____ ID#:_____

Psychological Services is a counseling center aimed at delivering high quality care for our student population. To this end, Psychological Services operates as a training site with the aid of licensed mental health providers as well as trainee clinicians at different stages of obtaining their doctorate degree in clinical psychology. Clinicians in training are supervised by licensed clinical psychologists (Dr. Jennifer Zizzo, Dr. Tabatha Stewart, Dr. Peter Arnold, and Dr. Deepti Vaswani).

Psychological Services is open from **8 A.M.-5 P.M. Monday-Friday** during the spring and fall semesters, and **8 A.M.- 3:30 P.M.** during summer session. Psychological Services is closed during holidays, and for spring and winter break. Psychological Services has a crisis clinician available during business hours if necessary for any urgent or emergent concerns. If you are experiencing a crisis outside of our business hours, please call the national crisis line at **1-800-273-8255** or **988**, go to your local emergency room, call **911** or campus police at **559-244-5911.**

What to expect from counseling

Counseling is a confidential process designed to help you address your concerns, come to a greater understanding of yourself, and learn effective personal and interpersonal coping strategies. It involves a relationship between you and a trained therapist who has the desire and willingness to help you accomplish your individual goals. Counseling involves sharing sensitive, personal, and private information that may at times be distressing. During the course of counseling, there may be periods of increased distress. The outcome of counseling is often positive, however, the level of satisfaction for any individual is not predictable. Your therapist is available to support you throughout the process.

As a new client, you are eligible to receive **6 sessions** your first semester after you have paid your health service fee (there are no additional fees for psychological services received at SCCCD). A session is typically approximately **45-50 minutes long** in duration. As a returning client, you are eligible to receive **4 sessions** per semester. Based on your intake appointment, the clinician may decide it is in your best interest to refer you to group therapy, individual therapy, or to an off campus treatment provider.

Initials_____

Your Responsibility as a Client

Please note that if you do not call to cancel or reschedule within the 24 hour notification requirement, your no show/no call will count as one session. In the event that you no show/no call to two consecutive appointments, your file will be closed for the semester and you will be required to complete another Request for Services form. If you are referred for a diagnostic evaluation and would like a copy of the evaluation afterwards, please sign a Release of Information and arrange for a feedback session with an intern so they may explain the psychological results. If you are referred off campus for services you are responsible for their charges.

Initials_____

(Cont'd to next page)

Record Keeping

Psychological Services will maintain a confidential file that will contain client information. All information is viewed as privileged. If you would like to request documentation reflecting your treatment, please submit a release of information.

Initials_____

Confidentiality

All interactions with Psychological Services, including scheduling of or attendance at appointments, content of your sessions, progress in counseling, and your records are confidential. No record of therapy is contained in any academic, educational, or job placement file. You may request in writing that the psychological services staff release specific information about your counseling to persons you designate.

Exceptions to confidentiality:

1. When serious and foreseeable harm to you or others is evident.
2. When release of confidential information is required by court order or requested by you.
3. When child abuse or neglect is evident or suspected.
4. When one has expressed viewing, being in possession of, creating or distributing child pornography. This includes sending others explicit photos you have taken of yourself, if you or the recipient were under the age of 18 at the time.
5. When abuse, neglect or exploitation of adults who are vulnerable due to physical or mental impairment or advanced age is evident or suspected.
6. Psychological Services staff works as a team. Your therapist may consult with other counseling staff to provide the best possible care. These consultations are for professional and training purposes.

Initials_____

Video Recording Consent

I understand that because Psychological Services has a dual mission of providing services and training, my session may be observed by supervising clinicians. I understand that my session will be reviewed only by my therapist and their supervisor, in the interest of providing the best services for me and improving supervision for the clinician in training.

Initials _____

Complaints

If there is an issue that you would like to have addressed, discuss the issue with your clinician. If necessary, contact the Psychological Services Coordinator via writing. Contact information can be found via the Madera Community College Faculty Directory (https://www.maderacollege.edu/_documents/mcc-directory.pdf)

Initials_____

I understand that there may be risks and benefits to therapy. If I have questions regarding the risks/benefits of therapy, I will discuss them with my clinician prior to starting therapy. I have read and discussed the above information with my therapist. I understand the risks and benefits of counseling, the nature and limits of confidentiality, and what is expected of me as a client of Psychological Services.

_____ _____

Client Signature Date Witness Signature Date