PERSONAL COUNSELING INTAKE FORM

SIERRA COLLEGE HEALTH SERVICES

Name:______________________________________ Date of Birth:___________________ Age:________

Preferred Name:_________________________________ (if different) Student ID: ________________________

Biological Sex: ☐Male ☐Female Gender Identity:_____________ Preferred Pronoun:____________

Address:___________________________________ City_____________________ State:______ Zip:_____________

Ethnicity:_____________________________ Marital Status:__________ Children?____________

Current living situation (Parents/Friends/Roommates etc.):____

Occupation Student &______________________________

Are you: ☐New to College ☐Transfer ☐Re-Entry ☐International Student (F1 Visa) ☐continuing Student

Major:___________________________________ Number of Units this Semester:_______________

Previous Counseling? ☐No ☐yes, if yes, When? With Whom? Reason?____________________________________

____

Current or chronic health problems:____

Current or recent medications:____

Are you experiencing any of the following:

☐Change in sleeping or eating habits? ☐Academic Problems?

☐Social problems? ☐Problematic use of drugs/alcohol?

☐Mood Swings? ☐Stress?

☐Unusual or bothersome thoughts? ☐Suicidal thoughts?

☐Anxiety? ☐Depression/sadness?

☐Self-esteem issues? ☐Irritability?

☐Recent loss/death? ☐Sexual Issues?

☐Relationship problems with: ☐Friend ☐Partner ☐Family member ☐Teacher ☐Others

Finish the following sentences:

My life would be so much better if:____

____

____

____

Counseling Policies

Limits of Confidentiality
Information discussed in the therapy session is held confidential and not shared without written or electronic permission except under the following conditions. State law mandates that mental health professionals report the following situations to the appropriate persons and/or agencies:

1. If a minor child, elderly individual or a dependent adult is being (or has been) physically or sexually abused or neglected, a clinician is required to report that information to the appropriated agency to assure the safety of the person.
2. If you present an imminent risk of serious injury to yourself, the clinician will take action to assure your safety. The clinician is required to release only as much information as necessary to protect your safety.
3. If you threaten serious harm to another person, the clinician is required to take actions to warn and protect the other person. Typically, this involves contacting the person who is being threatened and/or contacting the authorities. However, the clinician is obligated to release only as much information as is judged to be necessary to protect your safety.
4. When a release of records is court mandated.

Number of Visits
I will be allowed six (6) visits per semester and no more than 18 during my tenure at Sierra College. Once I have reached maximum, I will be referred to a provider in the community. Sierra College Health Services is not intended for counseling for long-term problems.

No-Show Policy
I understand that cancellation must be made 24-hours in advance of an appointment. Cancellation made less than 24-hours in advance, or failure to show for an appointment will be considered a "no-show".
I understand a $10.00 fee will be placed on my Health Services account and a hold will be placed in Banner if I do not cancel or reschedule 24-hours in advance of my appointment. After two "no shows", I will have the following options:

1. Schedule same day appointments, if available
2. Request a referral for a community resource

I understand that if I arrive late for my appointment, I may or may not be able to be seen.

Patient Rights

1. Receive respectful treatment
2. A safe environment
3. To report unethical and illegal behavior by the therapist
4. Ask questions about their therapy
5. Request and receive information about therapist's education and experience
6. Refuse to answer any questions or disclose information they do not wish to share

Patient responsibilities

1. Be on time for all appointments
2. Call at least 24 hours in advance to cancel or change appointments
3. Work as a team with their therapist to maximize benefits of short-term therapy
4. Know the limits of confidentiality

I have read the above policies and agree to comply with them.

Signature:______________________________ Date:____________________