 State Center Community College District

**Request for Psychological Services**

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

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Maiden Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_ Birthplace: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 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

Correspondence Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred method of contact? PHONE EMAIL

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Initial here to give permission to contact: \_\_\_\_\_\_\_\_\_

**LIMITED CONFIDENTIALITY**

**I**nformation 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**, **child abuse**, **elder abuse**, or **dependent adult abuse** 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

**IMPORTANT**: Campus Psychological Services uses a brief therapy model. Before initiating services, each student must first schedule and attend a **mental health screening appointment (usually 15-20 minutes)** to determine whether treatment is most appropriate through our campus psychological services or through another treatment provider. Based on the screening appointment, the clinician may decide it is in your best interest to refer you to a community (off-campus) treatment provider.

**Therapy appointments are 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 |
|  |  |  |  |  |

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

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**ETHNICITY:** *(e.g., African-American, Hispanic, Caucasian, etc.)*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**MARITAL STATUS**

 Never Married

 Live with Significant Other

 Married

 Separated

 Divorced

 Widowed

Who referred you to Psychological Services?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  Instructor |  Friend |  Self |  Family |  Counselor |  Coordinator |
|  Dean |  Vice President |  Nurse |  District Police |  Website | Other: \_\_\_\_\_\_\_\_\_ |

 Name of person who referred you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Check which services are of interest to you:  Individual Therapy  Group Therapy  Both

**OTHER CONCERNS**

 Spiritual concerns

 Gender identity issues

 Sexual identity/orientation questions

 Concerns about family

 Adjustments to college

 Cultural conflict or prejudice

 Financial problems

 Legal Problems

 Grief/loss

 Eating Disorder

 OTHER (specify):

**STRESS or ANXIETY CONCERNS**

 Fear or anxiousness

 Panic attacks

 Stress, worry

 Unwanted or persistent intrusive thoughts

 Restlessness or feeling keyed up or on edge

 Shyness/discomfort in social situations

**Check issues you are now having or have experienced within the last two weeks**

**EMOTIONAL CONCERNS**

 Sad, depressed, hopeless

 Tired, lack of energy

 Decrease in drive or motivation

 Isolation or feelings of loneliness

 Irritability, hostility, anger

 Feelings of worthlessness

 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

**Briefly describe your reasons for seeking therapy at this time:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Rate your current level of distress:**  MINIMAL MILD MODERATE SEVERE

**Have you received psychological treatment in the past?**  YES NO

 **If “YES”**, please complete the information below regarding your past treatment

|  |  |  |  |
| --- | --- | --- | --- |
| **When did you receive treatment?** | **Where did you receive treatment?** | **How long did you receive treatment?** | **What were you being treated for?** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**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?** | **Where were you hospitalized?** | **How long were you hospitalized?** | **For what reason were you hospitalized?** |
|  |  |  |  |
|  |  |  |  |

**What prescribed or over-the-counter medications are you currently taking?**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Medication** | **Dosage** | **Date Started** | **Purpose** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

 State Center Community College District

**Psychological Services Initial Screening**

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

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CONFIDENTIAL FORM – SHARE ONLY WITH THERAPIST

**PATIENT STRESS QUESTIONNAIRE**

**Over the last two weeks**, how often have you been bothered by any of the following?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Circle Answer****Check Boxes that Apply to you** | **Not at all** | **Several Days** | **More than half the days** | **Nearly Every Day** |
| 1 | Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| 2 | Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| 3 |  Trouble Falling or staying asleep Sleeping too much | 0 | 1 | 2 | 3 |
| 4 | Feeling Tired or having little energy | 0 | 1 | 2 | 3 |
| 5 |  Poor appetite Overeating | 0 | 1 | 2 | 3 |
| 6 | Feeling bad about yourself or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| 7 | Trouble concentrating on things such as reading the newspaper or watching television. | 0 | 1 | 2 | 3 |
| 8 |  Moving or speaking so slowly that other people could have noticed, or the opposite - being so fidgety or restless that you’ve been moving around a lot more than usual | 0 | 1 | 2 | 3 |
| 9 |  Thoughts that you would be better off dead, or Thoughts of hurting yourself in some way | 0 | 1 | 2 | 3 |
| (10) | **ADD COLUMNS ABOVE** |  |  |  |  |
|  |  | **TOTAL**  |  |
| 1 | Feeling nervous, anxious or on edge | 0 | 1 | 2 | 3 |
| 2 | Not being able to stop or control worrying | 0 | 1 | 2 | 3 |
| 3 | Worrying too much about different things | 0 | 1 | 2 | 3 |
| 4 | Trouble relaxing | 0 | 1 | 2 | 3 |
| 5 | Being so restless that it is hard to sit still | 0 | 1 | 2 | 3 |
| 6 | Becoming easily annoyed or irritable | 0 | 1 | 2 | 3 |
| 7 | Feeling afraid as if something awful might happen | 0 | 1 | 2 | 3 |
| (8) | **ADD COLUMNS ABOVE** |  |  |  |  |
| ***\*adapted from PhQ 9, GAD7, PC-PTSD and AUDIT 11/1/16*** | **TOTAL**  |  |

**TRAUMA SCREEN**

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that

**In the PAST MONTH**, you:

1. Have had nightmares about it or thought about it when you did not want to? YES NO
2. Tried hard not to think about it or went out of your way to avoid situations

that reminded you of it? YES NO

1. Were constantly on guard, watchful, or easily startled? YES NO
2. Felt numb or detached from others, activities, or your surroundings? YES NO

(3)

|  |
| --- |
| *One standard drink serving = 12 oz beer; 12 oz wine cooler; 5 oz wine; 4 oz brandy; or 1.5 oz 80 proof liquor* |
| **ALCOHOL SCREEN** | **0** | **1** | **2** | **3** | **4** |
| How often do you have one drink with alcohol? | Never | Monthly or less | 2-4 times per month | 2-3 times per week | 4+ times per week |
| How many drinks containing alcohol do you have on a typical day when you are drinking? | 1 or 2 | 3 or 4 | 5 or 6 | 7 to 9 | 10 or more |
| How often do you have four or more drinks on one occasion? | Never | Less than monthly | Monthly | Weekly | Daily or almost Daily |
| How often in the **LAST YEAR** have you… |  |  |  |  |
| ..found that you were not able to stop drinking once you had started? | Never | Less than monthly | Monthly | Weekly | Daily or almost Daily |
| …failed to do what was normally expected from you because of drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost Daily |
| …needed a first drink in the morning to get yourself going after heavy drinking?  | Never | Less than monthly | Monthly | Weekly | Daily or almost Daily |
| …had feelings of guilt or remorse after drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost Daily |
| …been unable to remember what happened the night before because you had been drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost Daily |
|  | **0** | **2** | **4** |
| Have you or someone else been injured as a result of your drinking? | NO | Yes, but not in the last year | Yes, during last year |
| Has a relative, friend, doctor or other healthcare worker been concerned about your drinking or suggested you cut down? | NO | Yes, but not in the last year | Yes, during last year |
| **(8) ADD COLUMNS ABOVE** |  |  |  |  |  |
| ***\*adapted from PhQ 9, GAD7, PC-PTSD and AUDIT 11/1/16*** |  |  | **TOTAL** |  |

**Are you currently in any physical pain?** YES NO

**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 Center

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Student Signature Date