

Personal Counseling Intake Form

Sierra College Health Services

Name: _____ Date of Birth: _____ Age: _____
Address: _____ City: _____ State: _____ ZIP: _____
Phone: _____ Health Insurance Co.: _____
Student Identification Number: _____
Ethnicity: _____ Marital Status: _____ Children? _____
Current living situation (Parents/Friends etc.): _____

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

Major: _____ Number of Units: _____

Previous Counseling? ☐ Yes ☐ No If yes, When? With Whom? Reason? _____

Current or chronic health problems: _____
Current or recent medications: _____

Are you experiencing any of the following?

- | | |
|---|---|
| <input type="checkbox"/> Change in sleeping or eating habits? | <input type="checkbox"/> Academic Problems? |
| <input type="checkbox"/> Social Problems? | <input type="checkbox"/> Problematic use of drugs/alcohol |
| <input type="checkbox"/> Mood Swings? | <input type="checkbox"/> Stress? |
| <input type="checkbox"/> Unusual or bothersome thoughts? | <input type="checkbox"/> Suicidal Thoughts? |
| <input type="checkbox"/> Anxiety? | <input type="checkbox"/> Depression/sadness? |
| <input type="checkbox"/> Self Esteem Issues? | <input type="checkbox"/> Irritability? |

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

What do you hope to achieve through counseling? _____

Counseling Policies

Limits of Confidentiality

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

- 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 appropriate agency to assure the safety of the person;
- 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.
- If you threaten serious harm to another person, the clinician is required to take action 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.

- d. 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 either 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 cancellations must be made 24-hours in advance of an appointment.

Cancellations 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:

-Schedule same day appointments, as available

-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 depending on what my counselor decides is best or if the appointment has already been filled.

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: _____