COS Health Center Counseling Intake Registration Form

OFFICE USE ONLY
Date Received: _____
Date Scheduled: _____
Assigned Therapist: _____

_____
Last Name First Middle

Banner ID/SSN_____Birth Date:_____Age: _____

_____
Local Address City, State Zip Code

Telephone #: (_____)_____ Cell Number: (_____) _____

Preferred method of contact: COS email ☐ text ☐ phone ☐

_____ _____ _____
Emergency Contact Name Relationship Emergency Contact phone #

_____ _____ (_____)_____
Medical Provider/Doctor City Area Code Telephone

Have you ever received mental health counseling before? ☐ Yes ☐ No

If yes, when, where and with whom? _____

APPOINTMENT AVAILABILITY DAYS & TIMES:_____

SERVICE REQUESTED: (The Health Center offers in-person or teletherapy counseling sessions. Please choose your preference.)

☐ In-person ☐ Teletherapy
☐ Individual counseling ☐ Couples/marital counseling **(both parties must be currently enrolled as COS students)**

CURRENT CONCERNS:

☐ Depression ☐ Anxiety ☐ Stress ☐ Grief and Loss
☐ Addiction or recovery issues ☐ Parenting Issues ☐ Relationship issues ☐ Victim of Abuse
☐ Difficulty adjusting to major life change ☐ Medical issues

CURRENT SYMPTOMS:

In the **past month**, have you experienced any of the following?

☐ Unusual weight gain or weight loss ☐ Change in sleep patterns ☐ Feelings of hopelessness
☐ Feeling like you want to die ☐ Loss of interest in activities you usually enjoy

RELATIONSHIP STATUS:

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other: _____

CHILDREN LIVING IN YOUR HOUSEHOLD:

Name _____ Age_____ Birth date _____

Name _____ Age_____ Birth date _____

Name _____ Age_____ Birth date _____

Name _____ Age_____ Birth date _____

CONFIDENTIAL INFORMATION AND REPORTING:

Under California law, the content of mental health treatment is confidential with the exception of a few specific situations. This means that the COS Student Health Center cannot release any information about you to anyone, including family members, without your written consent. **Exceptions to this privacy include incidents where a health services provider becomes aware of child abuse, elder or dependent adult abuse, and/or when a student presents a risk of harming themselves and/or others.** Furthermore, by initialing this form, I authorize the Mental Health and/or Nursing staff within COS Student Health Services to contact Tulare County Health & Human Services, Tulare County Mental Health Crisis, and/or the person listed on this form as an emergency contact, to disclose information pertaining to my immediate safety and assist me in receiving the services needed if/when the Mental Health and/or Nursing staff deem it necessary.

In addition to the previous exceptions, I understand patient information may be shared between medical/mental health providers within the Student Health Services Center.

Lastly, I understand sessions may be recorded for the purpose of reviewing the therapist's performance. The recording content will never be a part of the client's record and will never be used for any other purposes. Students will always be informed of possible recording beforehand and will be given the right of refusal. Any recordings taken will be permanently erased after supervisor's review.

COUNSELING AGREEMENT/CONSENT:

I hereby agree to participate in counseling at the College of the Sequoias Health Center. I understand I am responsible for scheduling and keeping appointments, and I further agree to give my counselor and the Health Center 24 hr. notice in the event of illness or cancellation of any counseling session. I understand that if I do not show for an appointment and make no attempt to cancel or reschedule the appointment will be subtracted from my total number of sessions. Two consecutive no shows will result in being removed from the schedule for that semester.

I understand the Student Health Center utilizes master's prepared, graduate level interns in the fields of marriage and family therapy and/or social work. I further understand the interns are supervised by Jill Maze, Licensed Clinical Social Worker, (BBS# 22068) who is approved by the California Board of Behavioral Sciences to practice mental health therapy and provide supervision to the aforementioned interns and associates. I agree to hold harmless and indemnify the College of the Sequoias District Governing Board, and it's respective officers, officials, employees, and agents from and against all losses, claims, demands, damages, alleged acts of malpractice, errors or omissions, and all costs and expenses incurred in connection with them resulting from or in connection with my participating in the College of the Sequoias Health Center counseling sessions and related activities, including, but not limited to, liability which results from my own negligence.

I have read and understand the above information regarding counseling at the College of the Sequoias Student Health Center.

Signature:_____Date:_____

If you have any questions regarding any aspect of the above confidentiality policy or the counseling agreement, please do not hesitate to ask the office staff and/or your counselor.

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OPTIONAL SURVEY

***Optional* demographic data is requested by California state funding sources:**

Which of the following best describes you?
Please select one answer.

- ☐ Hispanic
- ☐ White
- ☐ Asian
- ☐ African American
- ☐ Unknown
- ☐ Multi-Ethnicity
- ☐ Filipino
- ☐ Pacific Islander
- ☐ Native American
- ☐ Decline to state

Please choose your age group.

- ☐ Under 20 years
- ☐ 20 to 24
- ☐ 25 to 39
- ☐ 40 and over
- ☐ Decline to state

What is your gender?

- ☐ Female
- ☐ Male
- ☐ Non-Binary
- ☐ Decline to state

Thank you for helping us comply with our funding sources requests.