FOR COUN S ELOR US E ON LY:

TERM: FALL: ☐ **SPRING:** ☐ **SUMMER:** ☐ **YEAR:** _____ **INTAKE #:** _____

STUDENT HEALTH and wellness center

Caring for Mind, Body and Spirit

CLEAR FORM

PLEASE USE ADOBE ACROBAT TO FILL & SIGN FORM

LAS POSITAS COLLEGE

Counseling Request

Name: _____ W# _____

Zonemail Email: _____ Date: _____

Days and Times Available (50 min)

PLEASE CHECK ALL TIMES AVAILABLE **(place an "X" in box)**

HOURS	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
9:00 am	☐	☐	☐	☐	☐
9:30	☐	☐	☐	☐	☐
10:00	☐	☐	☐	☐	☐
10:30	☐	☐	☐	☐	☐
11:00	☐	☐	☐	☐	☐
11:30	☐	☐	☐	☐	☐
12:00 pm	☐	☐	☐	☐	☐
12:30	☐	☐	☐	☐	
1:00	☐	☐	☐	☐	
1:30	☐	☐	☐	☐	
2:00	☐	☐	☐	☐	
2:30	☐	☐	☐	☐	
3:00	☐	☐	☐	☐	
3:30	☐	☐	☐	☐	
4:00	☐	☐	☐	☐	
4:30		☐			
5:00		☐			
6:00		☐			

Additional Notes: (Learning Community {Puente, Movement, Umoja}, e-mail address, and if virtual or in-person sessions are preferred). Also any scheduling notes

_____

_____

_____

_____

_____

Name:_____W Number:_____Date:_____

CONSENT FOR TREATMENT

In the case of mental health services (personal therapy) permission is hereby granted to treat the student named below at the Las Positas Student Health and Wellness Center, and to make necessary referrals to private outside care, emergency mental health, and/or other community facilities as indicated or needed.

☐ **Click here to electronically give permission for the Las Positas College Student Health and Wellness Center to contact you via email. Please use assigned Zone Mail Account**

Check all that apply:

☐ **I give permission for counseling by Telemedicine**

Please return all forms to pgonsman@laspositascollege.edu

ATTENDANCE POLICY

Our office requires notification of cancellation at least 24-hours prior to the appointment or earlier if possible. A NO SHOW will be assigned to the appointment if we do not hear from you. Two (2) missing appointments, without notification, will result in your appointments being cancelled. If that occurs you will need to resubmit a request for services and you will be contacted by the next available AMFT for sessions. (Please note those sessions will pick up at the number you left on).

CONSENT FOR CARE

"By signing, I understand that failing to give a notice within 24 hours or "NO SHOWING" of an appointment will result in the aforementioned results. Further, I certify that I have been informed of my rights and responsibilities, the rules of confidentiality, and the responsibilities of the Las Positas Student Health and Wellness Center and the Associate Marriage and Family Therapists for onsite care."

Student Signature: _____ **Date:**_____

Witness: _____ **Date:**_____

LAS POSITAS
COLLEGE

To Whom It May Concern,

The Student Health & Wellness Center at Las Positas College receives and responds to complaints regarding the practice of psychotherapy by any unlicensed or unregistered counselor providing services at Las Positas College.

To file a complaint, contact:

Heike Gecox , LMFT #46097 Clinical Supervisor
Student Health & Wellness Center
3000 Campus Hill Drive | BLDG 1500 | Livermore, CA 94551
Office: (925) 424-1436 | Email: hgecox@laspositascollege.edu

Student Signature: _____

Date: _____

CLIENT/COUNSELOR CONTRACT

Psychological Services
Las Positas College

The information in this contract is designed to make clients aware of the extent and kind of counseling that they are currently entering.

1. I understand that the counseling service I am about to receive is from an Marriage Family Therapist Trainee who is earning a Master's Degree in Behavioral Science and is becoming qualified to be registered with the State of California. S/he is being supervised by Heike Gecox, a licensed Marriage & Family Therapist who is in good standing with the Board of Behavioral Sciences (BBS) in this State. The focus of this counseling will be on the clients' relationship functioning as it impacts their ability to be successful students.
2. I understand that due to the Trainee status of the Counselor, the information obtained in counseling sessions must be discussed with her/his supervisor, and relevant employees of Las Positas College, in order to assure me the highest quality of services in my best interest. None of this information will be shared with any person not involved in this process and will be treated as confidential with the exceptions cited below.
3. The limits of Confidentiality re as follows: should I reveal that I intend to harm myself, others, or in a situation of child or elder abuse, my counselor is a mandated reporter who must contact the appropriate authorities in order to take precautions for my safety and the safety of others.
4. Litigation Limitation: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure of confidential content, it is agreed that if there should be legal proceedings (such as, but not limited to, divorce and custody disputed, injuries, lawsuits, etc.) neither I nor my attorney(s), nor anyone else acting on my behalf will call on LPC counselors to testify in court or any other proceeding, nor will a disclosure of the psychotherapy records be requested.
5. I understand that this counseling service will be provided to me free of charge.
6. If I cannot attend a counseling session, I will give a 24-hour prior notice of cancellation by calling (925) 424-1830. I understand that if I do not cancel appointments appropriately, I may not receive further counseling services at Las Positas College.
7. This contract establishes that we will have ____ consecutive counseling sessions, after which time we will establish another contract **OR** my counseling goal(s) will be attained **OR** I will be referred to a community counseling service.

My signature below indicates that I fully understand, and agree to abide by, these terms.

CLIENT'S SIGNATURE PRINT NAME DATE

COUNSELOR'S SIGNATURE DATE

Information Form
Counseling Client

W#:_____ Name: _____ Preferred Name:_____

Preferred Pronouns:_____ Age: _____ DOB (Birthday): _____

Sex assigned at birth:_____ Gender Identity: ☐ FEMALE ☐ MALE ☐ TRANSGENDER ☐ NON-BINARY

Cell Phone: _____

Home Phone: _____ OK to leave a message? ☐ YES ☐ NO

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

Mailing Address:

_____

Street Address City Zip

Do you live with your parents? ☐ YES ☐ NO If yes, please list your parent's names:

_____

Emergency contact:

Name: _____

Relationship: _____ Telephone: _____

How long have you been attending Las Positas College?

_____

Have you ever received counseling services at Las Positas College? YES ☐ NO ☐
If yes, counselors name and year you received counseling: _____
What is your current occupation? _____

****

Please describe presenting concerns for seeking counseling at this time:

_____

_____

_____

What are your best hopes for the session(s)?:

_____

_____

Have there been any significant stressors or traumas in your life: losses, births, deaths, moves, hospitalizations, financial problems, in the last few years? YES ☐ NO ☐ If yes, please explain:

_____

Have you had any current or past psychiatric treatment or counseling? YES ☐ NO ☐ If yes, please explain:

_____

Have you been hospitalized for any psychological care? YES ☐ NO ☐ If yes, what was the presenting issue?

_____

Have you ever been suicidal? YES ☐ NO ☐ If yes, please explain:

_____

Are you currently having suicidal thoughts? YES ☐ NO ☐ If yes, please explain:

_____

Do you have any special needs? YES ☐ NO ☐ If yes, please explain:

_____

Are you currently taking any prescribed medications? YES ☐ NO ☐ If yes, what are you taking?

_____

Are you currently being treated for any chronic medical conditions? YES ☐ NO ☐ If yes, please explain

_____

Have you had any serious illnesses, accidents, or surgeries in the past? YES ☐ NO ☐ If yes, please explain: _____

Please mark an "X" by the appropriate description if you are experiencing any of these symptom

☐ Academic Stress
☐ Anger Problems
☐ Anxiety
☐ Depression
☐ Eating Disorder
☐ Family Problems
☐ Hearing Voices
☐ Financial Stress
☐ Grief/Loss
☐ Low Self-Esteem
☐ Mood problems
☐ Sexual Abuse
☐ Sleeping Problems
☐ Social Discomfort
☐ Vocational Stress

_____ _____

Client's Signature Date

Are you currently using alcohol/drugs? YES ☐ NO ☐ If yes, (amount, how often, intoxication frequency)

_____

What is your personal history of any alcohol/drug use?

_____

Does any member of your family have mental illness? YES ☐ NO ☐ If yes, please explain:

_____

Has anyone in your family used alcohol or drugs? YES ☐ NO ☐ If yes, please explain

_____

Describe your current relationship satisfaction with your family:

Mother:_____
Father:_____
Siblings: _____

Additional Notes:

_____
_____
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Las Positas College

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

"Notice of Privacy Practices" has been made available to me.

Client Signature Date

TERM: FALL: ☐ SPRING: ☐ SUMMER: ☐ YEAR: ____ INTAKE #: _____

NATIONAL DEPRESSION SCREENING DAY® – COLLEGE SCREENING FORM

1) Age: _____

2) Sex: _____ (M/F)

3) What year are you in college?
- ☐ Freshman
- ☐ Sophomore
- ☐ Junior
- ☐ Senior
- ☐ Graduate Student
- ☐ Other

4) Ethnic / Racial Group:
- ☐ African American
- ☐ American Indian
- ☐ Asian American
- ☐ Caucasian
- ☐ Hispanic
- ☐ Other

5) Do you live: (Check all that apply)
- ☐ On Campus
- ☐ Off Campus
- ☐ Alone
- ☐ With Roommates

6) Have you ever been treated for: (Check all that apply)

	Yes	No
Depression	☐	☐
Bipolar Disorder	☐	☐
Generalized Anxiety Disorder	☐	☐
Post-Traumatic Stress Disorder	☐	☐
If yes: Did treatment include medication	☐	☐

7) Have you ever been treated for: (Check all that apply)
- ☐ Alcohol Abuse
- ☐ Chronic Pain
- ☐ Diabetes
- ☐ Drug Abuse
- ☐ Eating Disorder
- ☐ HIV
- ☐ Seizure Disorder
- ☐ Thyroid Problem
- ☐ None of the above

Participant No. _____

8) Have you ever attempted suicide: Yes ☐ No ☐

THE HANDS® DEPRESSION SCREENING TOOL (The Harvard Department of Psychiatry / National Depression Screening Day® Scale)

Over the past two weeks, how often have you:	None or little of the time	Some of the time	Most of the time	All of the time	Staff Use Only
1. been feeling low in energy, slowed down?	○	○	○	○	
2. been blaming yourself for things?	○	○	○	○	
3. had poor appetite?	○	○	○	○	
4. had difficulty falling asleep, staying asleep?	○	○	○	○	
5. been feeling hopeless about the future?	○	○	○	○	
6. been feeling blue?	○	○	○	○	
7. been feeling no interest in things?	○	○	○	○	
8. had feelings of worthlessness?	○	○	○	○	
9. thought about or wanted to commit suicide?	○	○	○	○	
10. had difficulty concentrating or making decisions?	○	○	○	○	
				Total Score:	

THE MOOD DISORDER QUESTIONNAIRE

Please answer each question as best you can.	YES	NO	Staff Use Only
1. Has there ever been a period of time when you were not your usual self and...			
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	☐	☐	
...you were so irritable that you shouted at people or started fights or arguments?	☐	☐	
...felt much more self-confident than usual?	☐	☐	
...you got much less sleep than usual and found you didn't really miss it?	☐	☐	
...you were much more talkative or spoke much faster than usual?	☐	☐	
...thoughts raced through your head or you couldn't slow your mind down?	☐	☐	
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	☐	☐	
...you had much more energy than usual?	☐	☐	
...you were much more active or did many more things than usual?	☐	☐	
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	☐	☐	
...you were much more interested in sex than usual?	☐	☐	
...you did things that were unusual for you or that other people might have thought were excessive, foolish or risky?	☐	☐	
...spending money got you or your family into trouble?	☐	☐	
	Total Score:		
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	☐	☐	

3. How much of a problem did any of these cause you - like being unable to work; having family, money or legal troubles; getting into arguments or fights?
Please check (✓) **one response only.** ☐ No problem ☐ Minor problem ☐ Moderate problem ☐ Serious problem

See reverse for additional screening tools

CLINICIAN: FILL OUT SCREENING RECOMMENDATION SECTION (See box on reverse side)

TERM: FALL: ☐ SPRING: ☐ SUMMER: ☐ YEAR: ____ INTAKE #: _____

CARROLL-DAVIDSON GENERALIZED ANXIETY DISORDER SCREEN©

■ These questions are to ask about things you may have felt most days in the past six months.	YES	NO	Staff Use Only
1. Most days I feel very nervous.	☐	☐	
2. Most days I worry about lots of things.	☐	☐	
3. Most days I cannot stop worrying.	☐	☐	
4. Most days my worry is hard to control.	☐	☐	
5. I feel restless, keyed up or on edge.	☐	☐	
6. I get tired easily.	☐	☐	
7. I have trouble concentrating.	☐	☐	
8. I am easily annoyed or irritated.	☐	☐	
9. My muscles are tense and tight.	☐	☐	
10. I have trouble sleeping.	☐	☐	
11. Did the things you noted above affect your daily life (home life, or work, or leisure) or cause you a lot of distress?	☐	☐	
12. Were the things you noted above bad enough that you thought about getting help for them?	☐	☐	
Used with permission from Bernard Carroll, MD, PhD and Jonathan R.T. Davidson, MD. © Bernard J. Carroll, MD, PhD, and Jonathan R.T. Davidson, MD 2000.	Total Score:		

MODIFIED SPRINT (SPRINT-4©) PTSD SCREEN

If at any time you have experienced or witnessed a traumatic event, which involves loss of life, serious injury or threat of either: ■ **Please respond to these questions about how you have felt most days in the past week.**	YES	NO	Staff Use Only
1. Have you been bothered by unwanted memories, nightmares, or reminders of this event?	☐	☐	
2. Have you been making an effort to avoid thinking or talking about this event, or doing things which remind you of what happened?	☐	☐	
3. Have you lost enjoyment for things, kept your distance from people, or found it difficult to experience feelings?	☐	☐	
4. Have you been bothered by poor sleep, poor concentration, jumpiness, irritability, or feeling watchful around you?	☐	☐	
© Jonathan R.T. Davidson, MD, 2003. All rights reserved. For use in conjunction with National Depression Screening Day® only. Duplication or use for any other purpose is prohibited.	Total Score:		

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE.

PLEASE RETURN THIS FORM TO STAFF FOR SCORING.

SCREENING RECOMMENDATION (TO BE FILLED OUT BY CLINICIAN ONLY)

■ **I spoke with the participant and recommended: (Check all that apply)**

Follow-up for:
☐ Depression ☐ Bipolar Disorder ☐ No follow-up needed
☐ Generalized Anxiety Disorder ☐ Post-Traumatic Stress Disorder

■ **If a Community-Based Site:**
- ☐ Outpatient Referral
- ☐ Inpatient Referral
  - ☐ Voluntary
  - ☐ Emergency

■ **If a Primary Care Facility:**
- ☐ Treated in office
- ☐ Referred Elsewhere
- ☐ Emergency

National Depression Screening Day® is a program of Screening for Mental Health, Inc., a non-profit organization.

Las Positas Student Health and Wellness Center

3000 Campus Hill Drive, Building 1700, Livermore, CA 94551

Plan of Care for Behavioral Health (Navigator Questionnaire)

This section to be completed by STUDENT:

Date: _____ **W#:**_____

Name:_____ / **Preferred Name:**_____ **DOB:** _____

Do you have reliable transportation?: ☐ **YES** ☐ **NO**

Are you currently employed?: ☐ **YES** ☐ **NO** **Part Time:** ☐ **Full Time:** ☐

I give permission to the Las Positas College Student Navigator to contact me by phone/email: ☐ **Yes** ☐ **No**

If yes, please check preferred method.

☐ **Contact Email:**_____ ☐ **Contact Number:**_____

Would you like to receive information or assistance with any of the services listed below? Please check any or all that interest you. You may also discuss and/or complete this section during your session.

County for Services:	☐ **Alameda** ☐ **San Joaquin** ☐ **Contra Costa**
EXPEDITED SERVICES:	☐ **Food** ☐ **Housing** ☐ **Insurance (Health)**
Campus Services:	☐ **Tutoring** ☐ **Transfer Center** ☐ **Career Center** ☐ **DSPS**
Housing Services:	☐ **Currently Homeless** ☐ **Looking to move** ☐ **Rent Assistance** ☐ **Utility Payment Assistance (Electricity / Water)** **Are current services in your name?** ☐**yes** ☐**no** **Number in Household:** _____
Additional Counseling (Outside of LPC)	□ **Psychiatry** □ **Psychology/Personal** □ **Group** □ **Abuse (□Substance, □Physical, ☐Mental)**
Food Services:	☐ **CalFresh** ☐ **Food Banks** ☐ **Hot Meals/Meal Prep**
Other Services:	☐ **Clothing** ☐ **Financial** ☐ **Transportation**

Additional requests, notes, or questions for navigator:

_____

_____

_____

_____

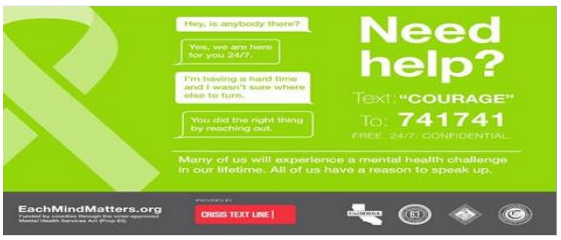
_____

Las Positas College Student Health & Wellness Center

Counseling Services Referrals

TEXT

"COURAGE" to 741741



CALL

988

ONLINE

www.ulifeline.org/laspositascollege

ULifeline

Your online resource for college mental health

La Familia Servicios Psico-Sociales:

- **1149 N. El Dorado Street, Stockton, CA 95202 (209) 468-2335**

Mental Health Services Vocational Rehabilitation Services:

- **1212 N. California Street, Stockton, CA 95202 (209) 468-8686**

Medi-Cal Counseling:

- **Alameda County: ACCESS PROGRAM: 1-800-491-9099**
- **Contra Costa County: ACCESS PROGRAM: 1-888-678-7277**
- **San Joaquin County: ACCESS PROGRAM: 1-209-468-9370**

NAMI:

- **1212 N California Street, Tracy, CA 95376 (209) 468-3755**

Tracy Adult Outpatient Clinic:

- **220 W. 11th Street, Tracy, CA 95376 (209) 831-5941**

Tri-Valley Sliding Scale Counseling:

- **Anthropos Counseling Center: (925) 449-7925 Counseling@Anthroposcounselling.Org**
- **Pleasanton Community Counseling Center: (925) 600- 9762**
- **Tri Valley Haven Counseling Center: (925) 449-5845**

Website to help find a therapist covered by your insurance co.

- **https://www.psychologytoday.com/**