OXNARD COLLEGE STUDENT HEALTH CENTER

CONFIDENTIAL INFORMATION FORM

Welcome to Oxnard College student Health and Psychological Services (SHPS) Please complete the following form for your counselor. If you are uncomfortable answering a question, you may skip it. The information will be kept confidential in accordance with SHPS Policy.

Today's date:	STUDENT ID NUMBER:

CLIENT INFORMATION

Last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one)

Enrolled Student? ❑ Yes ❑ No	Number of Units Enrolled In?	Ethnicity	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Cell:	Home phone no.:

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Length of time employed

Medical Insurance ❑ Yes ❑ No	Career Goal(s) MAJOR	Hours worked per week

Briefly describe the concerns that led you to seek counseling today:	

CLIENT INFORMATION

How would you describe your living situation? PEACEFUL CHAOTIC HAPPY UNHAPPY OTHER _____

Hobbies:	With whom do you live? List ages and relationship	How did you hear about us?

Is this your first time seeing a mental health counselor? ❑ YES ❑ NO	When and where were you last seen?	Academic Counselor?

EOPS OR CAL WORKS/ CARE STUDENT?	EAC REGISTERED STUDENT?	WHAT CLASSES ARE YOU TAKING THIS SEMESTER?	ARE YOU EXPERIENCING ACADEMIC DIFFICULTIES?

Please indicate areas of concern:	❑ Depression/ Mood	❑ Stress/ Anxiety	❑ Physical Health/ Medical	❑ Irritability/ Anger	❑ Relationships/ Marriage

❑ Family	❑ School	❑ Employment/ Finances	❑ Sleeping/ Eating	❑ Other _____

Areas you would like to improve upon or gain new knowledge about	❑ Depression Reduction	❑ Stress Management/ Anxiety	❑ Study Skills/ Time Management	❑ Anger Management	❑ Parenting
❑ Addiction	❑ School Support	❑Relationship Support	❑ Community Resources/ Referral	❑ Communication	❑ Other

Are you currently taking Medication:	❑ Yes	❑ No	Which ones?	

Prescribing Psychiatrist/ Physician?	Have you ever been hospitalized for mental health reasons?	Have you ever been in counseling before?	
Do you have any legal issues or concerns?	Alcohol or drug use?	Frequency?	

NAME:_____ DOB:_____ 900#_____ DATE: _____

Oxnard College Mental Health Screen

Please complete the front and back sections of this form

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Use "✔" to indicate your answer)

	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, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or 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 have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 +_____+_____+_____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work/school, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Staff Only: Date reviewed _____ Date entered in EHR _____ Initial _____

Rev 5/3/19

Please answer the following questions by placing a check in the YES or NO box	Past month	
Questions 1 and 2	**YES**	**NO**
1) ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) ***Have you had any actual thoughts of killing yourself?***		
If YES to 2, answer questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) ***Have you been thinking about how you might do this?*** e.g. *"I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it....and I would never go through with it."*		
4) ***Have you had these thoughts and had some intention of acting on them?*** as opposed to *"I have the thoughts but I definitely will not do anything about them."*		
5) ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?***		
6) ***Have you ever done anything, started to do anything, or prepared to do anything to end your life?*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **If YES,** ***Was this within the past 3 months?***	**Lifetime** **Past 3 Months**	

Information and Consent for Mental Health Counseling at the Student Health Center

Services provided

Oxnard College Student Health Center offers free short term individual and scheduled group counseling services. Each student is allowed 4 sessions per semester they are enrolled. The initial intake does not constitute as one session.

You must be a currently enrolled student and have paid the health fee to be eligible for services.

Mental health counseling can have both risks and benefits. The counseling process may include discussions of your personal challenges and difficulties which can elicit uncomfortable feelings such as sadness, guilt, anger and frustration. Counseling has also been shown to have many benefits. It can often lead to better interpersonal relationships, improved academic performance, solutions to specific problems and reduced distress. These benefits cannot be guaranteed for any particular person and depend greatly on your efforts.

Confidentiality

In keeping with ethical standards of the American Psychological Association, the Board of Behavioral Sciences and state and federal law, all services provided by the staff of the Health Center are kept confidential except as described below and in the accompanying Notice of Privacy Practices. We may confer with other Health Center staff about the best way to provide assistance to you.

As required by mental health practice guidelines and current standards of care, we will keep records of your counseling. Neither the fact that you seek counseling nor any information you tell us will appear in your student academic record unless you specifically ask us to communicate with other staff and faculty at the college.

Exceptions We have a legal responsibility to disclose information about you, even without your permission, when:

- You are likely to harm yourself or someone else unless protective measures are taken. If it appears that you are likely to harm or kill yourself or other people, or are a danger to the college community, we reserve the right to communicate and share information about you to the extent necessary to protect safety with the appropriate college authorities, and as appropriate, your parents, spouse or significant other, or other people or agencies who can protect safety.
- When there is reasonable suspicion of abuse of children, incapacitated adults or the elderly.
- When there is a valid court order for the disclosure of patient records.
- If you lack the capacity to care for yourself with regard to food, clothing or shelter.
- If you are under the age of eighteen, confidential information may also be disclosed to parents or guardians.

Fortunately, these situations are infrequent. By signing this form you also give the Student Health Center permission to communicate with your designated Emergency Contact if we believe that you are at risk. Please consult with your psychologist or counselor if you have any questions about confidentiality.

Mental Health Counseling Policies

Although we try to arrange initial counseling appointments promptly, a wait for appointments is common during busy periods of the year. If you consider your situation an emergency that will not allow a delay, please inform our staff. For after-hours emergency services: if on-campus, contact the Campus Police at 986-5805, if off-campus, either call 911 or go to the nearest hospital emergency room.

Many issues typically encountered by college students can be addressed with the short-term counseling we provide. Your initial session is an assessment session, devoted to defining your concerns, developing a treatment plan, and determining whether our services fit your needs. If at any point it is determined that other services are more suitable, we will help you obtain assistance from appropriate off-campus providers. Non-compliance with the plan we develop to assist you could result in the termination of services.

Please arrive on time for your appointments. Missed appointments reduce our capacity to provide services to other students. If you are unable to keep your appointment, please call to cancel or reschedule as far in advance as possible. **Same day cancellations and no-shows will count against the four-session limit for that semester**. Repeated cancellations or missed appointments may result in the termination of services.

Use of electronic mail

Please be aware that email is not private or confidential and we may not read it in a timely fashion. No counseling will be conducted via email.

Please sign below to indicate that you understand the above policies, have had the opportunity to ask questions and agree to participate in mental health counseling in accord with these policies.

_____ _____

Student's Printed Name & Signature Date

_____ _____

Therapist's Printed Name & Signature Date