

## State Center Community College District

## **Request for Psychological Services**

			n	ate:		
			D	ate		
Last Name:	First Name:	ID#				
Maiden Name:	DOB:	Birtl	nplace:	A	ge:	
Phone (primary):	OK to call?	YES NO	OK to leave	e a message?	YES N	10
Phone (secondary):	OK to call?	YES NO	OK to leave	e a message?	YES N	10
Correspondence Address:						
Email:	F	referred	method of conta	act? PHONE	EM	IAIL
Emergency Contact: Relations		nip:				
Emergency Contact Phone:	In	itial here	to give permissi	on to contact:		
	LIMITED CONFIDEN					$\neg$
Information shared with psycho circumstances. Psychologica others, child abuse, elder abu	staff are mandated repor	ters. Info	rmation related t	to <b>harm to self</b>	or	
Are you thinking of <b>harmi</b>	ng yourself?		YES NO	1		
Are you thinking of harming or killing another person?		son?	YES NO	1		
Are you having suicidal th	oughts?		YES NO	1		
	al health screening appoi through our campus psych ointment, the clinician may appointments are 50 m	ntment (u ological s decide it i	usually 15-20 m ervices or throug s in your best in ong and start a	inutes) to dete gh another treat terest to refer y at the top of t	rmine tment ou to a <b>he hou</b>	
0-11 /	e an easier time scheduli lity. Please keep this in				etter	

transgender, gender fluid, etc.)

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

## **MARITAL STATUS** ■ Never Married

- ☐ Live with Significant Other Married ☐ Separated ■ Divorced
- lacksquare Widowed

## PLEASE LIST ALL YOUR AVAILABLE TIMES BETWEEN 8AM to 4PM

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY

☐ Instructor ☐ Dean	☐ Friend ☐	vices? Self	☐ Family	☐ Counselor	☐ Coordinator
		Nurse	☐ District Police		Other:
Name of person	who referred you: _				
Check which se	rvices are of interest	to you:	☐ Individual Therapy	☐ Group Th	erapy 🗖 Both
Che	ck issues you are nov	v having c	or have experienced w	ithin the last tv	vo weeks
MOTIONAL CONCERNS  Sad, depressed, hope Tired, lack of energy Decrease in drive or it Isolation or feelings of Irritability, hostility, a Feelings of worthless Relationship concern HINKING CONCERNS Problems rememberi Difficulty making dec Hearing voices or see Told my behavior is of Poor concentration of Briefly describe  Rate your curren Have you receive	motivation of loneliness anger ness s ing isions and or eccentric or focus  t level of distress: ed psychological treaten	si CC D D D Sth D So D D So D So D So D So D So D So D	TRESS or ANXIETY DNCERNS I Fear or anxiousness I Panic attacks I Stress, worry I Unwanted or ersistent intrusive roughts I Restlessness or feeling eyed up or on edge Shyness/discomfort in ocial situations  Therapy at this time:	OTHER COI  Spiritual Gender Sexual id Concern Adjustm Cultural Financia Legal Pro Grief/los Fating D OTHER (	concerns identity issues dentity/orientation question s about family ents to college conflict or prejudice I problems oblems ss isorder specify):
mandated repo	v, I acknowledge th	at I have <b>of confid</b> t the pur	read and understand entiality as outlined pose of the mental h	I the clinician' on page 1 of t ealth screenin	s role as a his form. I also g appointment is

Date

Student Signature