SRJC STUDENT HEALTH SERVICES

SANTA ROSA JUNIOR COLLEGE

STUDENT INFORMATION

Name (please print) _____ Date _____

Name you would like us to call you (if different than above)_____

Address (where you are living right now)_____ City_____

SID or SSN#_____ Date of Birth: _____ Age:_____

Referred by: ___SRJC Faculty/Staff ___Friend/Student ___Student Health Services
___Family Member ___Self ___Other

Phone:(_____)_____ (*Circle one*) *home / cell* Ok to leave message? YES NO

Alternate Phone:(_____)_____ *(Circle one) home / cell* Ok to leave message? YES NO

Email we may contact you at if needed:_____

Emergency Contact Name: _____Relationship to you: _____

Phone: (_____)_____

Your Ethnicity: ___Caucasian/White ___Hispanic or Latino ___Asian
___African American/Black ___Native American ___Pacific Islander
___2 or more of the above ___Other

Do you have health insurance? YES NO

___Medi-Cal ___Kaiser ___Blue Shield ___Other

Do you smoke?

___Never smoked ___Formerly smoked ___Currently smoke some days
___Currently smoke every day

Allergies:_____

Current Medications:_____

Do you have <u>thoughts</u> of hurting yourself or others? YES NO

Do you <u>intend to act</u> on thoughts of hurting yourself or others? YES NO

Do you currently feel unsafe in your home environment? YES NO

Your Current Living Situation:

- ☐ **Alone**
- ☐ **With Partner**
- ☐ **With Children**
- ☐ **With family/parent**
- ☐ **With roommate**

Your Relationship Status:

- ☐ **Single**
- ☐ **Married**
- ☐ **Divorced**
- ☐ **Domestic Partner**
- ☐ **In significant relationship**
- ☐ **Widowed**

Sexual Orientation: _____ **Partner's name:** _____

Are you a veteran? **Yes** **No**

Employment History:

Company Name	Position	Hours/Week	Time Period

School Program/Area of Study: _____

Prior Education: _____

Do you have a disability? If so, please describe: _____

General Health: ☐ **Excellent** ☐ **Good** ☐ **Fair** ☐ **Poor**

Medical History:
Please list major illnesses, conditions, injuries or surgeries, with dates of diagnosis and treatment.

Current Physician: _____ ***Phone:*** _____

***Any <u>past</u>* Psychiatric/Psychotropic Medications and dosages:**

Medications	*Dosage*	*Date Started*	*Prescribing Physician*

Tell us about the people who raised you (check all that apply):

- ☐ Biological parents
- ☐ Married/Partnered
- ☐ Living together
- ☐ Divorced: Your: _____
- ☐ Mother Deceased: Date: _____
- ☐ Adoptive parents
- ☐ Foster Parents/Foster Care
- ☐ Never married
- ☐ Separated Date: _____
- ☐ Father Deceased Date: _____

Number of brothers and sisters: ☐ 1- 2 ☐ 3 or more

My family has a history of (check all that apply):

- ☐ Abuse
- ☐ Counseling
- ☐ Alcoholism
- ☐ Depression
- ☐ Eating Disorders
- ☐ Poor Communication
- ☐ Psychiatric Hospitalization
- ☐ None of these
- ☐ Other _____

Please describe any family history of psychiatric illness in your immediate/extended family:

_____

_____

_____

Are you currently in therapy (individual or other) with another therapist? ☐ Yes ☐ No

If, yes: Name: _____

Have you been seen at Student Psychological Services before? ☐ Yes ☐ No

If yes, Name of therapist you saw: _____

Year and semester you saw therapist: _____

Have you been in therapy before with someone outside of SRJC? ☐ Yes ☐ No

If yes, with whom: _____

If yes, when and for how long? _____

Have you been hospitalized in a psychiatric facility? ☐ Yes ☐ No

Please describe with date: _____

Describe your reasons/goals for seeking therapy at this time: _____

_____

_____

_____

Describe your current concerns: _____

_____

_____

_____

_____

My current concerns and symptoms are: (check all that apply)

- ☐ The continuation of a long-standing condition.
- ☐ A recent worsening of an ongoing condition.
- ☐ The recurrence of a previous condition.
- ☐ Significantly different from any previous condition.

My current Symptoms developed: (check all that apply)

- ☐ **The first occurrence of any condition.**
- ☐ **Suddenly (over less than four weeks)**
- ☐ **Gradually (over one to several months)**
- ☐ **Very gradually (over one to several years)**

What is your general mood lately? _____

Examples: calm; anxious; worried; sad; content; angry; irritated; despairing; other

Do you have any of the following: Regularly? (check all that apply)

- ☐ ***Headache***
- ☐ ***Back ache***
- ☐ ***Back Pain***
- ☐ ***Stomachaches***
- ☐ ***Mood changes***

How many hours do you sleep per night? _____

Does it feel adequate?	☐ **Yes**	☐ **No**
Do you have difficulties with sleep?	☐ **Yes**	☐ **No**
Has this changed recently?	☐ **Yes**	☐ **No**

Drugs & Alcohol (check all that apply) If yes, indicate how much:

- ☐ ***Tobacco:*** _____
- ☐ ***Heroin*** _____
- ☐ ***Alcohol*** _____
- ☐ ***Soda*** _____
- ☐ **Marijuana:** _____
- ☐ **Methamphetamine** _____
- ☐ **Other street drugs** _____
- ☐ **Caffeine (Tea, Coffee)** _____

The following has resulted from my drug/alcohol use:

- ☐ **Academic Problems**
- ☐ **Relationship Problems**
- ☐ **Black outs**
- ☐ **Other (specify)**
- ☐ **DUI or Traffic Violation**
- ☐ **Difficulties with memory**
- ☐ **Fight with a friend**

Please check if you have had an unwanted sexual experience (check all that apply):

☐ **Before age 18** ☐ **18 or older** ☐ **No** ☐ **Unsure** ☐ **Decline to Respond**

What recent life changes have you experienced? _____

Please mention anything else you would like to add: _____

Name:_____ Date:_____ Session:(Check One) First__ Middle__ Last__

INSTRUCTIONS: Please indicate how well each statement describes you, during the past two weeks. Select only one answer per statement, and please do not skip any questions.

	Not at all like me				Extremely like me	
1	0	1	2	3	4	I get sad or angry when I think of my family
2	0	1	2	3	4	I am shy around others
3	0	1	2	3	4	There are many things I am afraid of
4	0	1	2	3	4	My heart races for no good reason
5	0	1	2	3	4	I feel out of control when I eat
6	0	1	2	3	4	I enjoy my classes
7	0	1	2	3	4	I feel that my family loves me
8	0	1	2	3	4	I feel disconnected from myself
9	0	1	2	3	4	I don't enjoy being around people as much as I used to
10	0	1	2	3	4	I feel isolated and alone
11	0	1	2	3	4	My family gets on my nerves
12	0	1	2	3	4	I lose touch with reality
13	0	1	2	3	4	I think about food more than I would like to
14	0	1	2	3	4	I am anxious that I might have a panic attack while in public
15	0	1	2	3	4	I feel confident that I can succeed academically
16	0	1	2	3	4	I become anxious when I have to speak in front of audiences
17	0	1	2	3	4	I have sleep difficulties
18	0	1	2	3	4	My thoughts are racing
19	0	1	2	3	4	I am satisfied with my body shape
20	0	1	2	3	4	I feel worthless
21	0	1	2	3	4	My family is basically a happy one
22	0	1	2	3	4	I am dissatisfied with my weight
23	0	1	2	3	4	I feel helpless
24	0	1	2	3	4	I use drugs more than I should
25	0	1	2	3	4	I eat too much
26	0	1	2	3	4	I drink alcohol frequently
27	0	1	2	3	4	I have spells of terror or panic
28	0	1	2	3	4	I am enthusiastic about life
29	0	1	2	3	4	When I drink alcohol I can't remember what happened
30	0	1	2	3	4	I feel tense
31	0	1	2	3	4	When I start eating I can't stop
32	0	1	2	3	4	I have difficulty controlling my temper
33	0	1	2	3	4	I am easily frightened or startled
34	0	1	2	3	4	I diet frequently
35	0	1	2	3	4	I make friends easily
36	0	1	2	3	4	I sometimes feel like breaking or smashing things
37	0	1	2	3	4	I have unwanted thoughts I can't control
38	0	1	2	3	4	There is a history of abuse in my family
39	0	1	2	3	4	I experience nightmares or flashbacks
40	0	1	2	3	4	I feel sad all the time
41	0	1	2	3	4	I am concerned that other people do not like me
42	0	1	2	3	4	I wish my family got along better
43	0	1	2	3	4	I get angry easily
44	0	1	2	3	4	I feel uncomfortable around people I don't know
45	0	1	2	3	4	I feel irritable
46	0	1	2	3	4	I have thoughts of ending my life
47	0	1	2	3	4	I feel self conscious around others
48	0	1	2	3	4	I purge to control my weight
49	0	1	2	3	4	I drink more than I should
50	0	1	2	3	4	I enjoy getting drunk
51	0	1	2	3	4	I am not able to concentrate as well as usual
52	0	1	2	3	4	I am afraid I may lose control and act violently
53	0	1	2	3	4	It s hard to stay motivated for my classes
54	0	1	2	3	4	I feel comfortable around other people
55	0	1	2	3	4	I like myself
56	0	1	2	3	4	I have done something I have regretted because of drinking
57	0	1	2	3	4	I frequently get into arguments
58	0	1	2	3	4	I find that I cry frequently
59	0	1	2	3	4	I am unable to keep up with my schoolwork
60	0	1	2	3	4	I have thoughts of hurting others
61	0	1	2	3	4	The less I eat, the better I feel about myself
62	0	1	2	3	4	I feel that I have no one who understands me

ACKNOWLEDGEMENT OF RECEIPT OF "CLIENT AGREEMENT"
AND "NOTICE OF PRIVACY PRACTICES"

By signing and dating this form, I acknowledge having read, understood, and agreed to the contents of the Student Health Services Provider Notice of Privacy Rights and Student Psychological Services Client Agreement.

Printed Name:_____ **SID:** _____

Signature: _____ **Date:** _____