



Counseling Request

Name: _____

W# _____

Zonemail Email: _____

Date: _____

Days and Times Available

PLEASE CHECK ALL TIMES AVAILABLE

HOURS	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
9:00 am	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9:30	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10:00	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10:30	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11:00	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11:30	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12:00 pm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12:30	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
1:00	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
1:30	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2:00	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2:30	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3:00	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3:30	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4:00	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4:30		<input type="checkbox"/>			
5:00		<input type="checkbox"/>			
6:00		<input type="checkbox"/>			

Counselor Notes: (Use this section to provide additional notes, e-mail address, and if virtual or in-person sessions are desired)



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 session by phone

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: _____



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: _____

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:



Las Positas College

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

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

Client Signature

Date

NATIONAL DEPRESSION SCREENING DAY® – COLLEGE SCREENING FORM

<p>1) Age: _____</p> <p>2) Sex: _____ (M/F)</p> <p>3) What year are you in college?</p> <p><input type="checkbox"/> Freshman <input type="checkbox"/> Senior</p> <p><input type="checkbox"/> Sophomore <input type="checkbox"/> Graduate Student</p> <p><input type="checkbox"/> Junior <input type="checkbox"/> Other</p> <p>4) Ethnic / Racial Group:</p> <p><input type="checkbox"/> African American <input type="checkbox"/> Caucasian</p> <p><input type="checkbox"/> American Indian <input type="checkbox"/> Hispanic</p> <p><input type="checkbox"/> Asian American <input type="checkbox"/> Other</p>	<p>5) Do you live: (Check all that apply)</p> <p><input type="checkbox"/> On Campus <input type="checkbox"/> Alone</p> <p><input type="checkbox"/> Off Campus <input type="checkbox"/> With Roommates</p> <p>6) Have you ever been treated for: (Check all that apply) Yes No</p> <p>Depression <input type="checkbox"/> .. <input type="checkbox"/></p> <p>Bipolar Disorder <input type="checkbox"/> .. <input type="checkbox"/></p> <p>Generalized Anxiety Disorder <input type="checkbox"/> .. <input type="checkbox"/></p> <p>Post-Traumatic Stress Disorder <input type="checkbox"/> .. <input type="checkbox"/></p> <p>If yes: Did treatment include medication <input type="checkbox"/> .. <input type="checkbox"/></p>	<p>7) Have you ever been treated for: (Check all that apply)</p> <p><input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> HIV</p> <p><input type="checkbox"/> Chronic Pain <input type="checkbox"/> Seizure Disorder</p> <p><input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid Problem</p> <p><input type="checkbox"/> Drug Abuse <input type="checkbox"/> None of the above</p> <p><input type="checkbox"/> Eating Disorder</p> <p>8) Have you ever attempted suicide: <input type="checkbox"/> .. <input type="checkbox"/></p>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="text-align: left;">Participant No.</th> </tr> <tr> <td style="height: 40px;"> </td> </tr> </table>	Participant No.	
Participant 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?					

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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?	<input type="checkbox"/>	<input type="checkbox"/>	
...you were so irritable that you shouted at people or started fights or arguments?	<input type="checkbox"/>	<input type="checkbox"/>	
...felt much more self-confident than usual?	<input type="checkbox"/>	<input type="checkbox"/>	
...you got much less sleep than usual and found you didn't really miss it?	<input type="checkbox"/>	<input type="checkbox"/>	
...you were much more talkative or spoke much faster than usual?	<input type="checkbox"/>	<input type="checkbox"/>	
...thoughts raced through your head or you couldn't slow your mind down?	<input type="checkbox"/>	<input type="checkbox"/>	
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	<input type="checkbox"/>	<input type="checkbox"/>	
...you had much more energy than usual?	<input type="checkbox"/>	<input type="checkbox"/>	
...you were much more active or did many more things than usual?	<input type="checkbox"/>	<input type="checkbox"/>	
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	<input type="checkbox"/>	<input type="checkbox"/>	
...you were much more interested in sex than usual?	<input type="checkbox"/>	<input type="checkbox"/>	
...you did things that were unusual for you or that other people might have thought were excessive, foolish or risky?	<input type="checkbox"/>	<input type="checkbox"/>	
...spending money got you or your family into trouble?	<input type="checkbox"/>	<input type="checkbox"/>	
	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?	<input type="checkbox"/>	<input type="checkbox"/>	
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. <input type="checkbox"/> No problem <input type="checkbox"/> Minor problem <input type="checkbox"/> Moderate problem <input type="checkbox"/> Serious problem			

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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 <u>past six months</u>.	YES	NO	Staff Use Only
1. Most days I feel very nervous.	<input type="checkbox"/>	<input type="checkbox"/>	
2. Most days I worry about lots of things.	<input type="checkbox"/>	<input type="checkbox"/>	
3. Most days I cannot stop worrying.	<input type="checkbox"/>	<input type="checkbox"/>	
4. Most days my worry is hard to control.	<input type="checkbox"/>	<input type="checkbox"/>	
5. I feel restless, keyed up or on edge.	<input type="checkbox"/>	<input type="checkbox"/>	
6. I get tired easily.	<input type="checkbox"/>	<input type="checkbox"/>	
7. I have trouble concentrating.	<input type="checkbox"/>	<input type="checkbox"/>	
8. I am easily annoyed or irritated.	<input type="checkbox"/>	<input type="checkbox"/>	
9. My muscles are tense and tight.	<input type="checkbox"/>	<input type="checkbox"/>	
10. I have trouble sleeping.	<input type="checkbox"/>	<input type="checkbox"/>	
11. Did the things you noted above affect your daily life (home life, or work, or leisure) or cause you a lot of distress?	<input type="checkbox"/>	<input type="checkbox"/>	
12. Were the things you noted above bad enough that you thought about getting help for them?	<input type="checkbox"/>	<input type="checkbox"/>	
<small>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.</small>	Total Score:		

MODIFIED SPRINT (SPRINT-4[®]) PTSD SCREEN

<i>If at any time you have experienced or witnessed a traumatic event, which involves loss of life, serious injury or threat of either:</i> ■ Please respond to these questions about how you have felt most days in the <u>past week</u>.	YES	NO	Staff Use Only
1. Have you been bothered by unwanted memories, nightmares, or reminders of this event?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Have you been making an effort to avoid thinking or talking about this event, or doing things which remind you of what happened?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Have you lost enjoyment for things, kept your distance from people, or found it difficult to experience feelings?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Have you been bothered by poor sleep, poor concentration, jumpiness, irritability, or feeling watchful around you?	<input type="checkbox"/>	<input type="checkbox"/>	
<small>© 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.</small>	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: <input type="checkbox"/> Depression	<input type="checkbox"/> Bipolar Disorder <input type="checkbox"/> No follow-up needed
<input type="checkbox"/> Generalized Anxiety Disorder	<input type="checkbox"/> Post-Traumatic Stress Disorder
■ If a Community-Based Site:	■ If a Primary Care Facility:
<input type="checkbox"/> Outpatient Referral	<input type="checkbox"/> Treated in office
<input type="checkbox"/> Inpatient Referral	<input type="checkbox"/> Referred Elsewhere
<input type="checkbox"/> Voluntary	<input type="checkbox"/> Emergency
<input type="checkbox"/> Emergency	



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:

Navigator Date: _____

Navigator Name (Print): _____ **Signature:** _____

Assigned to MFT Trainee/Associate: Yes No

If Yes - Date: _____ **MFT Trainee/Associate Name (Print):** _____

MFT Trainee/Associate Signature: _____

Notes and Resources Provided:

Client Contacted: Yes No **Additional Information Needed:** Yes No

Date: _____

Notes and Resources Provided:

Client Contact: Yes No **Resources Provided:** Yes No

Date: _____

Notes and Resources:

Client Closed: Yes No

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@Anthroposcounseling.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/>