Dear Student:

Only a limited amount of counseling hours have been allotted to us. These times are very important and by far do not fulfill the need for student counseling.

Therefore, it is imperative that if you cannot keep your appointment you call at least twenty-four (24) hours in advance to cancel. Your appointment time can then be used for other students in need of counseling.

Thank you for your cooperation on this matter.

I have read and understand the above.

____ ____________________

Student Signature Date

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____ ____________________

Student Signature Date

CONFIDENTIAL INTAKE FORM:

Name: ____ Date of Birth: _____________

Address: ____

Soc. Sec. # ________________________ Marital Status: ___________ # of Children: __________

May we phone you, if necessary? If yes, home # _______________ work #________________

Emergency Contact: ____

How did you learn about our counseling services?
self friend instructor other ____________________

MAIN ISSUES OF CONCERN: Please check all that apply.

depression	anxiety/stress	alcohol/other drug use	studying/test taking
sexual issues	eating disorders	low self esteem	separation
grief, loss	finances	learning disability	sexual, physical and/or emotional abuse

relationships with: friends family instructors other

COUNSELING HISTORY:

Are you currently receiving counseling? yes _____ no _____

Name: ______________________ Address: ____

Have you previously received counseling? yes _____ no _____

Name: ______________________ Address: ____

CURRENT HEALTH STATUS:

Current illnesses: _________________________Current medications: _________________________

Chronic illnesses:_________________________ Recent medications: _________________________

Alcohol/Drug Use: weekly daily occasionally none

How many times per week do you exercise? _________________________

CLASS SCHEDULE:

Major _______________________ Total Units ____________

I agree to receive counseling services from the COC counseling staff and understand the client rights and stated limitations of confidentiality.

Signature: ____ Date: ______________________

COLLEGE OF THE CANYONS
STUDENT HEALTH & WELLNESS CENTER
COUNSELING SERVICES

LIMITS OF CONFIDENTIALITY

Information discussed in the therapy setting is held confidential and not shared without written permission except under the following conditions:

1. If the student threatens suicide.
2. If the student threatens harm to another person(s), including murder, assault, or other physical harm.
3. If the student under eighteen (18) reports that he/she is being abused, including but not limited to, physical beatings and sexual abuse.
4. Child Abuse - Reporting is legally mandated when there is knowledge or "reasonable suspicion" drawn from any professional contact.
5. If ordered by a Federal or State court.

State law mandates that counseling professionals must report these situations to the appropriate persons and/or agencies. Further, as a registered intern/trainee who is under the supervision of a licensed practitioner, therapy sessions will be discussed with a supervisor as deemed under the laws of the state. Communications between the counselor and student will otherwise remain confidential under the laws of the state.

COUNSELING POLICIES

Eligibility for counseling at the Student Health & Wellness Center is contingent upon my status as a fully enrolled student. Delivery of services from the Student Health & Wellness Center shall be based upon the mutual determination of myself and the staff as to the appropriateness of the services for the needs presented. The counselor, if he/she sees the need, will consult with other COC Student Health & Wellness Center medical, dietetic or counseling staff. If Student Health & Wellness Center staff are unable to provide services, I understand that I will be given referrals to resources more appropriate to my needs and goals.

Students are entitled to a maximum of six (6) sessions per semester. Counseling is intended for short-term problems and/or crisis intervention. If a twenty-four (24) hour notification of cancellation or change is not given, appointment will count as one of your scheduled visits. If you are more than ten (10) minutes late for your appointment, we reserve the right to give your time to another student and your scheduled session will count as one (1) of your appointments.

Having read and understood the above, I agree to the limits of confidentiality and to the policies of the Student Health & Wellness Center regarding counseling services.

Student Name (please print): ____

Signature: ______________________________________ Date:___________________________

CLIENT'S BILL OF RIGHTS

You have the right to:

receive respectful treatment that will be helpful to you;
receive a particular type of treatment without obligation or harassment;

a safe environment, free from sexual, physical and emotional abuse;

report unethical and illegal behavior by a therapist;

ask questions about your therapy;

request and receive information about the therapist's professional capabilities, including licensure, education, training, experience, professional association membership, specialization, and limitations;

refuse to answer any question or disclose any information you choose not to reveal;

know the limits of confidentiality and the circumstances when a therapist is legally required to disclose information to others;

know if there are supervisors, consultants, students or others with whom your therapist will discuss your case;

request, and in most cases, receive a summary of your file including the diagnosis, your progress, and type of treatment;

request the transfer of a copy of your file to any therapist or agency you choose;

receive a second opinion at any time about your therapy or therapist's methods;

request that the therapist inform you of your progress.