

**Counseling & Psychological Services (CAPS)
University of California, San Diego**

INTAKE FORMS PACKET

Included in this Packet

- (1) Information & Consent Form (2 copies, pp. 2-3)
- (2) Intake Questionnaire (pp. 4-10)
- (3) Notice of Privacy Practices (pp. 11-12)
- (4) Acknowledgment of Receipt of NPP (p. 13)

Instructions

Before your Appointment:

- (1) Read and Sign/Date the **Office Copy** of the **Information & Consent Form**
(Keep the *Student Copy* that is printed for you)
- (2) Complete the **Intake Questionnaire**
- (3) You may review the **Notice of Privacy Practices (NPP)**
- (4) Sign/Date the **Acknowledgment of Receipt of NPP**

Bring to your Appointment:

- (1) The signed Office Copy of the **Information & Consent Form**
- (2) The completed **Life Functioning Inventory**
- (3) The signed **Acknowledgment of Receipt of NPP**

If you have any questions regarding these forms, please call (858) 534-3755.

OFFICE COPY

UNIVERSITY OF CALIFORNIA, SAN DIEGO
COUNSELING AND PSYCHOLOGICAL SERVICES
(858) 534-3755

Name _____

Student ID A _____

INFORMATION AND CONSENT FORM

Services Provided

UCSD Counseling and Psychological Services (CAPS) offers a variety of individual, couples, and group counseling services provided by psychologists, psychiatrists, psychology interns, and practicum students.

Eligibility for evaluation or treatment from CAPS is contingent upon status as a fully enrolled student paying the Student Registration Fee.

Counseling and psychotherapy 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. However, 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 reductions in your feelings of distress. But, there is no assurance of these benefits.

Confidentiality

In keeping with ethical standards of the American Psychological Association and state and federal law, all services provided by the staff of CAPS are kept confidential except as noted below and in the accompanying Notice of Privacy Practices. We consult as needed within the staff of CAPS about the best way to provide the assistance that you might need. If UCSD Student Health Services (SHS) or the Student Safety Awareness Program (SSAP) is collaborating in your care, we may communicate about you with SHS and/or SSAP staff. As required by psychological practice guidelines and current standards of care, we keep records of your counseling. Neither the fact that you seek counseling nor any information disclosed in the counseling sessions will appear in your student academic record unless you specifically direct us to communicate with other staff and faculty at the university

CAPS professional staff have a legal responsibility to disclose client information without prior consent when a client is likely to harm himself, herself or others unless protective measures are taken, when there is reasonable suspicion of abuse of children, dependent adults or the elderly, when the client lacks the capacity to care for him or herself and when there is a valid court order for the disclosure of client files. Fortunately these situations are infrequent. By signing this form you also give CAPS permission to communicate with the Emergency Contact that you have designated if we believe that you are at risk. Please consult with your psychologist if you have any questions about confidentiality.

Counseling Policies

Although we try to arrange initial counseling appointments promptly, a waiting list 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, go to the nearest hospital emergency room or contact the UCSD Police at (858) 534-4357.

Many issues typically encountered by university 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 CAPS can meet 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 as far in advance as possible. Repeated cancellations or missed appointments may result in the termination of counseling.

Our goal is to provide the most effective psychotherapeutic experience. If you feel that your counselor is not a good match for you, we encourage you to discuss this matter with your current counselor. Alternatively, you can speak with the Clinical Director of CAPS. Either of the above can facilitate a transfer to a different counselor, if necessary. If you have questions or comments about our services, please ask at your initial appointment, fill out a Client Experiences Survey (CES) or arrange to speak with our Director.

CAPS is a training site for psychologists

CAPS is an American Psychological Association approved training site. Thus, the counseling you receive may be from a pre or post-doctoral psychology intern, practicum student or in special limited programs from a university student peer educator. All counselors in training will inform you of their trainee status as well as the name of their psychologist supervisor who can be contacted through our central office. In order to adequately supervise trainees, a supervisor may require that your counseling session be audio or video recorded. By signing this form you agree to have your sessions recorded if your counselor is in training. Staff psychologists may also wish to record counseling sessions for the purpose of training others, but will ask your permission to do so. You may choose not to be recorded if your counselor is not a trainee. All recordings are kept confidential in the same manner as your treatment records and will be erased after supervisory review. Please talk with your counselor if you have questions about audio and video recording.

Use of electronic mail

Please be aware that e-mail may not be private or confidential and may not be read by the recipient in a timely fashion.

Psychiatry

CAPS also offers time-limited psychiatric medication assessment and management services provided by psychiatrists. Eligibility for psychiatric medication services is contingent upon concurrent active treatment with a CAPS psychotherapist.

Psychiatric Medications

New medications will be prescribed only during psychiatry medication office visits, so that your psychiatrist can perform a current assessment of your condition and discuss with you the risks and benefits that may be associated with a new medication, and its alternatives.

It is your responsibility to request medication refills in a timely manner. If you need a prescription refilled, it is strongly preferred that you request a new prescription from your psychiatrist during a scheduled office visit. This will allow your psychiatrist to re-evaluate your condition and address any of your concerns. If you run out of your medication prior to your scheduled psychiatry visit, contact your psychiatrist. The psychiatrist will only authorize a refill in the exact amount necessary to provide treatment continuity until the soonest possible medication follow-up appointment. Please allow 7 business days for refill requests to be processed, and be aware that some medications cannot be legally refilled via telephone. To safeguard patient health, refills for medications will not be authorized if you have not been evaluated by your psychiatrist within the past 90 days. Routine medication refills are authorized only during regular business hours.

Please sign below to indicate that you understand and agree to participate in counseling in accord with the above policies.

Print Name

Signature

Date

STUDENT COPY

UNIVERSITY OF CALIFORNIA, SAN DIEGO
COUNSELING AND PSYCHOLOGICAL SERVICES
(858) 534-3755

Name _____

Student ID A _____

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Please sign below to indicate that you understand and agree to participate in counseling in accord with the above policies.

Print Name

Signature

Date

UC San Diego Counseling & Psychological Services (CAPS) Student Information Form

First Name: _____	MI: _____	Last: _____
Birth date: _____ / _____ / _____ day month year	Current Age: _____	Student ID#: _____

SECTION A: STUDENT INFORMATION

(A1) GENDER: Female Male Transgender Other (identify) _____

(A2) ETHNICITY

<input type="checkbox"/> African/American	<input type="checkbox"/> Korean/Korean American	<input type="checkbox"/> White/Caucasian
<input type="checkbox"/> Chicano/Mexican American/Puerto Rican	<input type="checkbox"/> Latino/Latino American/Hispanic	<input type="checkbox"/> Multiracial/Multiethnic
<input type="checkbox"/> Chinese/Chinese American	<input type="checkbox"/> Middle Eastern	<input type="checkbox"/> Other (_____)
<input type="checkbox"/> East Indian/Pakistani	<input type="checkbox"/> Native American/Alaskan Native	<input type="checkbox"/> Prefer Not to Answer
<input type="checkbox"/> Filipino	<input type="checkbox"/> Polynesian/Micronesian	
<input type="checkbox"/> Japanese/Japanese American	<input type="checkbox"/> Vietnamese/Vietnamese American	

(A3) SEXUAL ORIENTATION:

Bisexual Heterosexual Lesbian/Gay Queer Questioning Other (identify) _____

(A4) RELATIONSHIP STATUS:

Single Partnered Married Separated Divorced Widowed Other (specify) _____

(A5) RESIDENCE (check and specify in detail below):

Residence Hall/Apartment _____ Graduate Student Housing

Fraternity/Sorority Off-campus Residence

Parent's/Relative's Home Other _____

Local Residence Address: (e.g. Tioga Hall, Muir College, Street, City, State, Zip)

(A6) CONTACT INFORMATION (check all that apply):

Cell Phone #: _____ OK to phone OK to leave message

Home or other Phone #: _____ OK to phone OK to leave message

Preferred E-mail address: (Please be aware that email might not be confidential.) _____

OK to email you regarding your appointment

OK to email you an evaluation survey regarding your experience with counseling

(A7) PREFERRED METHOD OF CONTACT:

Cell Phone Home Phone Email Mail Other (specify) _____

(A8) EMERGENCY CONTACT:

Name: _____ Relationship: _____ Phone: _____

Address: _____

(A9) ACADEMIC STATUS:

Fr SO JR SR Grad Student Medical Student SIO Student

Pharmacy School Rady School Student's Spouse/ Partner Other _____

If you are a GRADUATE STUDENT, please specify the type of degree: Masters Doctorate Other _____

(A10) ACADEMIC INFORMATION:

Major/Academic Department _____ Units this Quarter _____

High School GPA _____ Community College GPA (if applicable): _____ UCSD GPA _____

(A11) ARE YOU CURRENTLY EMPLOYED?

Yes On-Campus Off-Campus Number of hours worked per week _____

No

(A12) CO- or EXTRA-CURRICULAR ACTIVITIES: (please list below)

(A13) UCSD UNDERGRADUATE COLLEGE:

- Revelle
 Muir
 Marshall
 Warren
 Roosevelt
 Sixth College
 N/A

(A14) OTHER INFORMATION: (check YES for those groups that apply to you and answer corresponding follow-up questions)

- a) VETERAN** Yes – Branch of Military _____ Time of Service: _____ No
b) INTERNATIONAL STUDENT Yes – Country _____ No
c) TRANSFER STUDENT Yes (specify below) No
 Transfer from: _____ 2-Yr Institution 4-Yr Institution
d) STUDENT WITH DISABILITIES: Yes (specify below) No
 If yes, are you officially diagnosed? Yes - Diagnosis: _____ No
 Are you officially registered with the UCSD Office with Student Disabilities (OSD) program? Yes No
e) FIRST IN YOUR IMMEDIATE FAMILY TO ATTEND COLLEGE (excluding siblings): Yes No
f) HAVE YOU EVER BEEN IN ANY CATEGORY OF ACADEMIC DIFFICULTY WHILE AT UCSD? Yes No
 If YES, check if applicable: Academic Probation Subject to Dismissal Other

(A15) REFERRED BY: (check all that apply)

- Self (see below) Professor/TA Friend Dean Academic Advisor
 Student Health Medical Provider Parent Other (specify) _____
 If Self, how did you hear about our services?
 Our Website TritonLink Website Other Website Orientation Presentation
 Library Walk Event Other

(A16) HEALTH INSURANCE COVERAGE:

- SHIP (University Plan) Private Insurance (specify name of insurance plan) _____

SECTION B: PRESENTING CONCERNS

(B1) Briefly describe what brings you to the Counseling and Psychological Services (CAPS):

(B2) Approximately how long has this concern been bothering you?

- Day Week Month Several months Year Several years Most of my life

(B3) Please CHECK ITEMS THAT APPLY. Check only those which apply to your presenting concern(s):

- | | | |
|--|---|--|
| <input type="checkbox"/> a) Academic concerns | <input type="checkbox"/> s) Episodes of manic behavior | <input type="checkbox"/> kk) Obsessive thoughts |
| <input type="checkbox"/> b) Addictions | <input type="checkbox"/> t) Faculty/advisor concerns | <input type="checkbox"/> ll) Panic Attacks |
| <input type="checkbox"/> c) ADHD/learning problems | <input type="checkbox"/> u) Family problems | <input type="checkbox"/> mm) Paranoia |
| <input type="checkbox"/> d) Adjustment to UCSD | <input type="checkbox"/> v) Feeling doomed or helpless | <input type="checkbox"/> nn) Phobias |
| <input type="checkbox"/> e) Adjustment to new situations | <input type="checkbox"/> w) Financial concerns | <input type="checkbox"/> oo) Physical abuse or assault |
| <input type="checkbox"/> f) Alcohol or drug concerns | <input type="checkbox"/> x) Graduation preoccupations | <input type="checkbox"/> pp) Procrastination |
| <input type="checkbox"/> g) Anger management | <input type="checkbox"/> y) Harassment | <input type="checkbox"/> qq) Re-entry concerns |
| <input type="checkbox"/> h) Anxiety, fear, nervousness | <input type="checkbox"/> z) Identity/sense of self | <input type="checkbox"/> rr) Relationship concerns |
| <input type="checkbox"/> i) Career/job concerns | <input type="checkbox"/> aa) Impulse control | <input type="checkbox"/> ss) Sexual abuse or sexual assault |
| <input type="checkbox"/> j) Compulsive Behavior | <input type="checkbox"/> bb) Internet/videogame concerns | <input type="checkbox"/> tt) Sexuality concerns |
| <input type="checkbox"/> k) Concentration difficulties | <input type="checkbox"/> cc) Intimate relationship concerns | <input type="checkbox"/> uu) Sleep difficulties |
| <input type="checkbox"/> l) Concern with other's well-being | <input type="checkbox"/> dd) Interpersonal concerns | <input type="checkbox"/> vv) Spiritual or religious concerns |
| <input type="checkbox"/> m) Cultural/multicultural concerns | <input type="checkbox"/> ee) Legal concerns | <input type="checkbox"/> ww) Stress or tension |
| <input type="checkbox"/> n) Cutting or self injury | <input type="checkbox"/> ff) Loneliness | <input type="checkbox"/> xx) Thinking about suicide |
| <input type="checkbox"/> o) Depression, sadness | <input type="checkbox"/> gg) Loss, grief, death | <input type="checkbox"/> yy) Thoughts racing through your mind |
| <input type="checkbox"/> p) Discrimination | <input type="checkbox"/> hh) Self-esteem | <input type="checkbox"/> zz) Trouble making decisions or getting things done |
| <input type="checkbox"/> q) Eating concerns/body image | <input type="checkbox"/> ii) Medical or health concerns | <input type="checkbox"/> aaa) Other presenting concern (specify below) |
| <input type="checkbox"/> r) Emotional or psychological abuse | <input type="checkbox"/> jj) Mood swings | _____ |

For Question #B4, use the following scale:

Low Intensity: 1----2----3----4----5: High Intensity

(B4) Please indicate by letter, which of the above concerns are most important to you: (e.g., "c", "gg", "mm")

	Rate the Intensity of this concern					Rate your current level of distress regarding this concern				
Most Important: _____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Second Most Important: _____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Third Most Important: _____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

SECTION C: LEVEL OF IMPACT

(C1) How much do your concerns interfere with your: (use scale below)

Low Interference: 1----2----3----4----5: Severe Interference

Academic Performance : Low: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5: Severe	Emotional Well-being: Low: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5: Severe
Social Relationships/Social Activities: Low: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5: Severe	Daily Routine: Low: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5: Severe

(C2) Due to the impact of your concerns on your Academic Performance, are you considering:

- Withdrawing for the quarter Not enrolling next quarter Dropping Out Transferring
 Other: (specify) _____ Not Applicable

SECTION D: MENTAL HEALTH HISTORY

(D1) Have you received counseling or psychotherapy in the past:

- Never Prior to high school High school Before attending UCSD at UCSD

(D2) Are you a returning client to UCSD Counseling and Psychological Services (CAPS)?

- Yes (specify below) No

If YES, when did you receive counseling services at CAPS, and who was the mental health provider/counselor:
(e.g., :Fall 2002, Dr. Psychologist name") _____

(D3) Are you currently receiving psychiatric services, professional counseling, or psychotherapy elsewhere?

- Yes (specify below) No

If YES, please provide the mental health provider's name and phone number:
(e.g., : "Dr. Provider Name, 555-555-5555") _____

(D4) Have you been proscribed psychiatric medication in the PAST?

- Yes (specify below) No

If YES, were you proscribed psychiatric medication at any time prior to your attendance at UCSD?

- Yes No

Please list what medications, dosage, and when taken:
(e.g., "Prozac, 20mg, 2002-2004") _____

(D5) Are you CURRENTLY taking prescribed psychiatric medication, antidepressants, or others?

- Yes (specify below) No

If YES, please list any psychiatric medications you are CURRENTLY taking and the prescribing psychiatrist/physician:
(e.g., "Prozac, 20mg, Family Doctor") _____

Are the medications helpful?

- Yes No

(D6) Have you been hospitalized for psychiatric reasons? Yes (specify below) No

If YES, please specify reason for past hospitalization: (check all that apply):

- Psychological problems Suicide ideation/attempt Dangerousness to others Drug/alcohol Other (specify below)

Please specify when and where you were hospitalized: (e.g., "2002, Hospital Name") _____

If you marked OTHER above, also describe the reason for your hospitalization: _____

Was the hospitalization helpful? Yes No

(D7) Have you ever had thoughts of harming yourself? Yes No

(D8) Have you purposely injured yourself without suicidal intent? (e.g., cutting, hitting, burning, etc.) Yes (specify below) No

If YES, when did this occur? In the past but stopped In the past and currently going on Recently started

(D9) In the last few days, have you had suicidal thoughts? Yes (specify below) No

If YES, answer the following questions:

FREQUENCY: Rarely Sometimes Frequently Always
DURATION: Seconds Minutes Hours Constant
INTENSITY: Brief and fleeting Focused deliberation Intense rumination

(D10) Have you seriously considered attempting suicide in the past? Yes (specify below) No

If YES, please describe: (e.g., age, issues, what happened) _____

(D11) Have you made a suicide attempt? Yes (specify below) No

If YES, please describe when and the nature of the attempt: _____

Did you receive help? Yes (specify below) No

If YES, please describe when and the nature of the help you received: _____

(D12) Have you seriously considered harming another person? Yes (specify below) No

If YES, describe when, who, and how: _____

(D13) Have you ever intentionally physically harmed someone? Yes (specify below) No

If YES, describe when, who, and how: _____

(D14) Do you CURRENTLY have thoughts of harming another person? Yes (specify below) No

If YES, please describe: _____

SECTION E: SUBSTANCE USE

(E1) Do you regularly use alcohol? Yes (specify below) No

(E2) In a typical month, how often do you have 4 OR MORE DRINKS in a 24-hour period?

Never Rarely Monthly Weekly Daily or Almost Daily

(E3) Do you consider your alcohol consumption a problem? Yes No Not Applicable

(E4) Have you used any drug in the past 30 days that was not prescribed by a doctor? (e.g., marijuana, meth, cocaine, diet pills, ecstasy, Xanax, valium, Ritalin, Adderall, LSD, acid, mushrooms, heroin, codeine, or other) Yes (specify below) No

If YES, indicate which substance(s) and when:

(E5) How often do you engage in recreational drug use? Never Rarely Monthly Weekly Daily or Almost Daily

(E6) Do you consider your drug use a problem? Yes No Not Applicable

(E7) Have you ever received treatment for alcohol or drug use? Yes (specify below) No

If YES, indicate when, where, and substance(s)

Was it helpful? Yes No

(E8) What is your typical DAILY CAFFEINE intake?

Never or infrequently 12-24oz OR 1-2 cups/servings 25-60 oz OR 3-5 cups/servings More than 60oz OR 5+ cups/servings

(E9) What is your typical DAILY NICOTINE intake?

Never or infrequently Less than 5 cigarettes 5-20 cigarettes More than 20 cigarettes Other (e.g., nicotine patch)

SECTION F: HEALTH & SOCIAL ISSUES

(F1) When was your last physical exam? _____

(F2) How is your physical health at present? Poor Unsatisfactory Satisfactory Good Excellent

(F3) Have you had any serious accidents, injuries, or illnesses?? Yes (specify below) No

If YES, please describe: _____

(F4) Are you presently taking any medications? (e.g., prescribed medications, over-the-counter drugs, alternative remedies, etc.)

Yes (specify below) No If YES, please list: _____

(F5) Please list any PERSISTENT PHYSICAL SYMPTOMS or health concerns: (e.g., chronic pain, headaches, hypertension, diabetes, etc.)

(F6) Are you having any problem with your sleep habits?

- No problems Sleeping too much Sleeping too little Poor quality of sleep Disturbing dreams
 Other (please describe)

(F7) How many times per week do you exercise? One or less Two to Four Five or more
For about how long each time?

(F8) Are you having difficulty with appetite or eating habits?

- No difficulty Eating less Eating more Binging Restricting Significant weight change
 Other (specify below)

Please describe the nature of your eating habits or weight change:

(e.g., frequency of eating patterns, how much weight lost and time frame, etc .

(F9) Do you have any problems or worries about sexual functioning? (check all that apply)

- No concerns Lack of desire Performance problem Sexual impulsiveness
 Difficulty maintaining arousal Worried about sexually transmitted disease Other (specify below)

If OTHER, please describe:

(F10) Besides family members, approximately how many people can you really count on right now for friendship and emotional support?

(F11) Approximately how many significant intimate relationships (lasting 6 months or more) have you been involved in the last couple of years?

(F12) Are you in a significant intimate relationship now?

SECTION G: FAMILY & CULTURAL BACKGROUND

(G1) Please list the members of your current family, including ages and occupations(e.g., "Mother, 50, accountant")

(G2) Were you and both your parents born in the USA? Yes No (specify below)

If NO, please describe who was foreign-born, where, and what was the approximate age of immigration: _____

(G3) In general, how happy or adjusted were you growing up?

- Not at all Unsatisfactory Average Substantially Completely

(G4) Does your family speak a language other than English at home? No Very little Sometimes Moderately Strongly

If YES, what language(s): _____

(G5) What is your ethnic identity? _____

(G6) How much do you identify with your ethnic heritage? Not at all A little Somewhat Moderately Strongly

(G7) How much conflict in values do you currently experience with your parents?

- Very little or none Some Moderate Strong Extreme

(G8) Religious preference: _____ Are you currently active in your religion? Yes No

(G9) How much is your immediate family a source of emotional support for you?

- Not at all A little Somewhat Substantial Very strong

(G10) Have you personally experienced LEGAL PROBLEMS? Yes No

If YES, please describe: _____

(G11) Did you experience LEARNING PROBLEMS in elementary or high school?

- None A little Some Substantial A lot, constant struggle

(G12) Do you have children? Yes No If YES, please list age and gender of children: _____

(G13) Please check any past, present, or impending special problems in your family. Please specify the problem, family member(s), and time of occurrence:

- a) DIVORCE/MARITAL PROBLEMS b) SERIOUS PHYSICAL ILLNESS, DISABILITY, OR DEATH c) ALCOHOL/SUBSTANCE ABUSE PROBLEMS
 d) PSYCHIATRIC ILLNESS/EMOTIONAL PROBLEMS e) FINANCIAL PROBLEMS/UNEMPLOYMENT f) LEGAL PROBLEMS
 g) OTHER _____

THE FLOURISHING SCALE

Please answer the following questions are about how you have been feeling in the past month. Place a check mark in the box that best represents how often you have experienced or felt the following:

In the past month, how often did you feel ...	NEVER	ONCE OR TWICE	ABOUT ONCE A WEEK	2 OR 3 TIMES A WEEK	ALMOST EVERY DAY	EVERY DAY
1) Happy						
2) Interested in life						
3) Satisfied						
4) That you had something important to contribute to society						
5) That you belonged to a community (like a social group, your school, or your neighborhood)						
6) That our society is becoming a better place						
7) That people are basically good						
8) That the way our society works made sense to you						
9) That you liked most parts of your personality						
10) Good at managing the responsibilities of your daily life						
11) That you had warm and trusting relationships with others						
12) That you had experiences that challenged you to grow and become a better person						
13) Confident to think or express your own ideas and opinions						
14) That your life has a sense of direction or meaning to it						

Thank you for completing the Intake Questionnaire.

THIS NOTICE DESCRIBES HOW MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY OBTAIN ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

The University of California, including the University Health Services is a teaching and research institution. Graduate students, fellows and residents may participate in your care as a part of their mental health training programs. All care is overseen and supervised by a licensed mental health professional. All information describing your mental health treatment and related health care services ("mental health information") is personal, and we are committed to protecting the privacy of the personal and mental health information you disclose to us. We are required by law to maintain the confidentiality of information that identifies you and the care you receive. When we disclose information to other persons and companies to perform services for us, we require them to protect your privacy, too. This Notice also applies to your psychologist, counselor, psychiatrist and other health care professionals who provide care to you. We must also provide certain protections for information related to your medical diagnosis and treatment, including HIV/AIDS, and information about alcohol and other substance abuse. We are required to give you this Notice about our privacy practices, your rights and our legal responsibilities.

WE MAY USE AND DISCLOSE YOUR MENTAL HEALTH INFORMATION:

For TREATMENT For example, we may give information about your psychological condition to other health care providers to facilitate your treatment, referrals or consultations.

For PAYMENT For example, we may contact your insurer to verify what benefits you are eligible for, to obtain prior authorization, and to receive payment from your insurance carrier.

For HEALTHCARE OPERATIONS For example, we give information to University psychological and medical services staff to review the quality of care provided, for performance improvement or for the training of health professionals.

For APPOINTMENTS AND SERVICES to remind you of an appointment, or tell you about treatment alternatives or health related benefits or services.

To INDIVIDUALS INVOLVED IN YOUR CARE, such as your parents, if you are a minor, or your conservator.

WITH YOUR WRITTEN AUTHORIZATION We may use or disclose mental health information for purposes not described in this Notice only with your written authorization

WE MAY USE YOUR MENTAL HEALTH INFORMATION FOR OTHER PURPOSES WITHOUT YOUR WRITTEN AUTHORIZATION

As REQUIRED BY LAW when required or authorized by other laws, such as the reporting of child abuse, elder abuse or dependent adult abuse.

For HEALTH OVERSIGHT ACTIVITIES to governmental, licensing, auditing, and accrediting agencies as authorized or required by law including audits; civil, administrative or criminal investigations; licensure or disciplinary actions; and monitoring of compliance with law.

In JUDICIAL PROCEEDINGS in response to court/administrative orders, subpoenas, discovery requests or other legal process.

To PUBLIC HEALTH AUTHORITIES to prevent or control communicable disease, injury or disability, or ensure the safety of drugs and medical devices.

To LAW ENFORCEMENT for, example, to assist in an involuntary hospitalization process.

To THE STATE LEGISLATIVE SENATE OR ASSEMBLY RULES COMMITTEES for legislative investigations.

For RESEARCH PURPOSES subject to a special review process, and the confidentiality requirements of state and federal law.

**UNIVERSITY HEALTH SERVICES –
NOTICE OF PRIVACY PRACTICES (cont'd)**

To PREVENT A SERIOUS THREAT TO HEALTH OR SAFETY of an individual. We may notify the person, tell someone who could prevent the harm, or tell law enforcement officials.

To PROTECT CERTAIN ELECTIVE OFFICERS including the President, by notifying law enforcement officers of potential harm.

YOU HAVE THE FOLLOWING RIGHTS:

1. To Receive a Copy of this Notice when you obtain care.
2. To Request Restrictions. You have the right to request a restriction or limitation on the mental health information we disclose about you for treatment, payment or health care operations. You must put your request in writing. We are not required to agree with your request. If we do agree with the request, we will comply with your request except to the extent that disclosure has already occurred or if you are in need of emergency treatment and the information is needed to provide the emergency treatment.
3. To Inspect and Request a Copy of your Mental Health Record except in limited circumstances. A fee will be charged to copy your record. You must put your request for a copy of your records in writing. If you are denied access to your mental health record for certain reasons, we will tell you why and what your rights are to challenge that denial.
4. To Request an Amendment and/or Addendum to your Mental Health Record. If you believe that information is incorrect or incomplete, you may ask us to amend the information or add an addendum (addition to the record) of no longer than 250 words for each inaccuracy. Your request for amendment

and/or addendum must be in writing and give a reason for the request. We may deny your request for an amendment if the information was not created by us, is not a part of the information which you would be permitted to inspect and copy, or if the information is already accurate and complete. Even if we accept your request, we do not delete any information already in your records.

5. To Receive An Accounting of Certain Disclosures we have made of your mental health information. You must put your request for an accounting in writing.

6. To Request That We Contact You By Alternate Means (e.g., fax versus mail) or at alternate locations. Your request must be in writing, and we must honor reasonable requests.

CHANGES TO THIS NOTICE: We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice on the UC website: <http://psychservices.ucsd.edu>

CONTACT INFORMATION: If you have any questions about this Notice, please contact the HIPAA Privacy Officer at: Counseling and Psychological Services, UCSD HS, 9500 Gilman Drive 0304, La Jolla, CA 92093-0304, or by telephone at 858 534 3755.

If you believe your privacy rights have been violated, you may file a complaint with the UHS HIPAA Privacy Officer or with the Secretary of the Department of Health and Human Services.

You will not be penalized for filing a complaint.

Effective Date: October 10, 2003

OFFICE COPY

**UNIVERSITY OF CALIFORNIA, SAN DIEGO
COUNSELING AND PSYCHOLOGICAL SERVICES
9500 Gilman Drive MC 0304
La Jolla, CA 92093-0304
(858) 534-3755/FAX (858) 534-2628**

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

The Counseling and Psychological Services Notice of Privacy Practices provides information about how we may use and disclose protected health information about you.

In addition to the copy we will provide you, copies of the current notice are available by accessing our website at <http://psychservices.ucsd.edu> and may be obtained at our Central Office at 190 Galbraith Hall.

I acknowledge that I have received the Notice of Privacy Practices.

Signature of Client or Client's Representative

Date

Print Name

Student ID

Interpreter (if applicable) _____

Relationship to Client _____

WRITTEN ACKNOWLEDGMENT NOT OBTAINED

Please document your efforts to obtain acknowledgment and reason it was not obtained.

- Notice of Privacy Practices Given – Client Unable to Sign
- Notice of Privacy Practices Given – Client Declined to Sign
- Notice of Privacy Practices and Acknowledgment Mailed to Client
- Other Reason Client Did Not Sign _____

Signature of PCS Representative

Date

Print Name