**PSYCHOLOGICAL SERVICES**

**Student Information Form**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

(street number) (city) (zip code)

**Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OK to leave a message on this phone? [ ] Yes [ ] No**

**Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OK to send a message to this email? [ ] Yes [ ] No**

**Birth date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_**

**Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  (Name/Relationship/Phone)

**Gender:**

**[ ] Male [ ] Female [ ] Transgender MTF / FTM [ ] Genderqueer [ ] Prefer not to answer**

**Sexual Orientation: [ ] Heterosexual [ ] LGBTQQAIP please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Ethnicity: Background Information:**

**[ ] African American [ ] International Student**

**[ ] Asian/Pacific Islander (Specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] Veteran**

**[ ] Caucasian [ ] Homeless**

**[ ] Hispanic(Please Specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] First Generation Student**

**[ ] Native American [ ] Work Part-Time**

**[ ] Other (Please Specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] Work Full-Time**

**Are you affiliated with these learning communities on campus? [ ] EOPS [ ] DSPS [ ] SSRS**

**Major: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expected graduation/transfer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medical conditions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Reasons for seeking counseling: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**[ ] Anxiety, nervousness, worry [ ] Problems with family [ ] Gambling**

**[ ] Depression, sadness [ ] Problems with friends [ ] Eating concerns**

**[ ] Anger, irritability, mood swings [ ] Problems with partner [ ] Sleep concerns**

**[ ] Loneliness, isolation, withdrawal [ ] Sexual abuse, rape [ ] Financial problems**

**[ ] Self-esteem, body image issues [ ] Physical abuse [ ] Housing problems**

**[ ] Concentration, memory [ ] Emotional abuse [ ] Legal problems**

**[ ] Stress, trouble coping [ ] Harassment, stalking, threats [ ] Alcohol use**

**[ ] School/work problems [ ] Sexuality, coming out [ ] Marijuana use**

**[ ] Medical problems/concerns [ ] Cultural, religious conflict [ ] Drug use**

**[ ] Grief, significant loss [ ] Internet/video game addiction [ ] Suicidal thoughts**

**Previous therapy or personal counseling experience: [ ] Yes [ ] No**

**When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**