**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: \_\_\_\_\_\_\_\_ Preferred Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**Gender:**

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

**Preferred pronoun: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**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? Full-time?**

**[ ] Other (Please Specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Where? \_\_\_\_\_\_\_\_\_\_\_ Hours/week? \_\_**

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

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

**Medical conditions/Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**[ ] Anxiety/Nervousness/Worry [ ] Problems with family [ ] Grief/Significant loss**

**[ ] Depression/Sadness [ ] Problems with friends [ ] Eating concerns**

**[ ] Anger/Irritability/Mood swings [ ] Problems with partner [ ] Sleep concerns**

**[ ] Loneliness/Isolation/Withdrawal [ ] Sexual Assault/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/Drug use**

**[ ] School/work problems [ ] Internet/video game addiction [ ] Sexuality/Coming out**

**[ ] Medical problems/concerns [ ] Cultural/Religious conflict [ ] Suicidal thoughts**

**Are you currently seeing a therapist outside of De Anza College? [ ] Yes [ ] No**

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

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

**When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Rev. 1/2020**