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:
- [ ] African American
- [ ] Asian/Pacific Islander (Specify) ________________
- [ ] Caucasian
- [ ] Hispanic (Please Specify) ______________________
- [ ] Native American
- [ ] Other (Please Specify) ________________________

Background Information:
- [ ] International Student
- [ ] Veteran
- [ ] Homeless
- [ ] First Generation Student
- [ ] Work – Part-Time? Full-time?

Where? ____________ Hours/week? __

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
- [ ] Depression/Sadness
- [ ] Anger/Irritability/Mood swings
- [ ] Loneliness/Isolation/Withdrawal
- [ ] Self-esteem/Body image issues
- [ ] Concentration/Memory
- [ ] Stress, trouble coping
- [ ] School/work problems
- [ ] Medical problems/concerns
- [ ] Problems with family
- [ ] Problems with friends
- [ ] Problems with partner
- [ ] Sexual Assault/Rape
- [ ] Physical abuse
- [ ] Emotional abuse
- [ ] Harassment/Stalking/Threats
- [ ] Internet/video game addiction
- [ ] Cultural/Religious conflict
- [ ] Grief/Significant loss
- [ ] Eating concerns
- [ ] Sleep concerns
- [ ] Financial problems
- [ ] Housing problems
- [ ] Legal problems
- [ ] Alcohol/Drug use
- [ ] Sexuality/Coming out
- [ ] 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?** __________________

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