



PSYCHOLOGICAL SERVICES

Student Information Form

Name: _____ Student ID: _____ Date: _____

Address: _____

Phone: _____ OK to leave a message on this phone? ☐ Yes ☐ No

Email: _____ OK to send a message to this email? ☐ Yes ☐ No

Emergency Contact: _____
(Name/Relationship/Phone)

Birth date: _____ Age: _____ Ethnicity: _____

Gender: _____ Pronouns: _____ Sexual orientation: _____
(optional) (optional)

Major: _____ Expected graduation/transfer: _____

Medical conditions: _____

Medications: _____ Health insurance: _____

Reasons for seeking counseling: _____

- | | | |
|--|--|---|
| <input type="checkbox"/> Anxiety, nervousness, worry | <input type="checkbox"/> Problems with family | <input type="checkbox"/> Gambling |
| <input type="checkbox"/> Depression, sadness | <input type="checkbox"/> Problems with friends | <input type="checkbox"/> Eating concerns |
| <input type="checkbox"/> Anger, irritability, mood swings | <input type="checkbox"/> Problems with partner | <input type="checkbox"/> Sleep concerns |
| <input type="checkbox"/> Loneliness, isolation, withdrawal | <input type="checkbox"/> Sexual abuse, rape | <input type="checkbox"/> Financial problems |
| <input type="checkbox"/> Self-esteem, body image issues | <input type="checkbox"/> Physical abuse | <input type="checkbox"/> Housing problems |
| <input type="checkbox"/> Concentration, memory | <input type="checkbox"/> Emotional abuse | <input type="checkbox"/> Legal problems |
| <input type="checkbox"/> Stress, trouble coping | <input type="checkbox"/> Harassment, stalking, threats | <input type="checkbox"/> Alcohol use |
| <input type="checkbox"/> School/work problems | <input type="checkbox"/> Sexuality, coming out | <input type="checkbox"/> Marijuana use |
| <input type="checkbox"/> Medical problems/concerns | <input type="checkbox"/> Cultural, religious conflict | <input type="checkbox"/> Drug use |
| <input type="checkbox"/> Grief, significant loss | <input type="checkbox"/> Internet/video game addiction | <input type="checkbox"/> Suicidal thoughts |

Counseling goals? _____

Previous therapy or personal counseling experience: ☐ Yes ☐ No

When? _____ How long? _____

How did you hear about Psych Services? _____