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
[ ] Student athlete
[ ] 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/Allergies: _____**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
[ ] Medical problems/concerns
[ ] Problems with family
[ ] Problems with friends
[ ] Problems with partner
[ ] School/work problems
[ ] Physical/Emotional abuse
[ ] Cultural/Religious conflict
[ ] Harassment/Stalking/Threats
[ ] Internet/video game addiction
[ ] Grief/Significant loss
[ ] Eating concerns
[ ] Sleep concerns
[ ] Sexual Assault/Rape
[ ] Housing problems
[ ] Sexuality/Coming out
[ ] Alcohol/Drug use
[ ] Suicidal thoughts

Do you have health insurance? [ ] Yes [ ] No Health insurance plan: _____
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?** _____