WWCC Counseling Services CONFIDENTIAL Student Demographic Form

Name: _____ Student ID #_____ Date: _____

Please complete the following information at your discretion:

Date of Birth: _____ Age: _____ Sexual Orientation: _____

Gender Identity: _____ What is your area of study? _____

Are you a veteran, dependent or active service member? _____

Have you ever been involved in the foster care system? _____

Please complete the information below:

Current Address: _____

City: _____ State: _____ Zip: _____

Phone 1: (Cell) _____ permission to leave voicemail? Yes or No (circle one)

Student E-Mail: _____

May we contact you at your student email? ☐ Yes ☐ No ***Please be aware, WWCC e-mail is not a secure or confidential means of communication. Information sent by e-mail through a state agency is public record. Do not send sensitive information via e-mail.**

Check the Appropriate Boxes:

☐Full-time student	☐Full-time employed	☐Not working at this time
☐ Part-time student	☐ Part-time employed	☐Retired

Do you need information about the following resources? (Please check any that apply):

☐ Food	☐ Health Insurance	☐ Specialized Mental Health Care	☐ Basic Needs
☐ Housing	☐ Safety	☐ Medical Care	☐ Other: _____

Please check all the concerns that apply for *your* reason for being here today.

☐ Abuse	☐ Guilt/Shame	☐Stress
☐ Academic Issues	☐ Health Issues	☐ Substance Use
☐ Anger/Aggression	☐ Hallucinations	☐ Suicidal Thoughts
☐ Anxiety Symptoms	☐ Intrusive Thoughts	☐ Suicide Attempt
☐ Attention/Concentration Issues	☐ Legal Issues ☐ LGBTQ Related Issues	☐ Test Anxiety
☐ Career Guidance	☐ Low Self-Esteem	☐ Thoughts of Harm to Others
☐ Depression Symptoms	☐ Relationship Issues	☐ Traumatic events
☐ Eating/Appetite/Weight Issues	☐ Resource Needs (i.e. food, housing, etc.)	☐ OTHER:
☐ Family Conflict	☐ Safety Issues	
☐ Financial Difficulties	☐ Self-Injuring Behaviors	
☐ Grief/Loss	☐ Sleep Problems	

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