EMPLOYEE COUNSELING FORM

Name: _____ **Reporting Date:** _____

Date of birth (Day, Month, and Year): _____

Relationship Status: Single / Married / Divorced / Widowed

Highest Degree Obtained: _____

Was this subject (Academic majors) your first priority? Yes No

Employment History: _____

Job Title and Department: _____

How long have you been on your present job: _____

Residence: In-Campus / Off- Campus:

Mother Tongue: _____ **Home town:** _____

Contact No: _____ **E-Mail:** _____

Preferred Method of Contact

- ☐ **Phone** ☐ **Email** ☐ **Personal Presence**

Referred by

- ☐ **Rector/Pro-Rector** ☐ **Self** ☐ **Administration**
- ☐ **DG/Dean/Teacher** ☐ **Family** ☐ **Friend**
- ☐ **Medical Doctor**

Basic Information

1. **Father's Name:** .....
2. **Father's Age, Profession, Education:** .....
3. **Are both parents living?** .....
4. **Mother's Age, Profession (if any), Education:** .....
5. **Number of siblings?** .....
6. **Your Rank among brothers and sisters?** .....
7. **Siblings: Age, Marital status, Education, Profession (According to birth order)**

If married:

8. **How many years of marriage?** .....
9. **Number of children:** .....
10. **Please list the names and ages of your children (according to birth order)**

11. **Any mishap/ trauma faced by you/ your family?** .....
12. **How many fast friends do you have?** .....
13. **Have you ever been abroad?** .....
14. **What do you like most?** .....
15. **Have you ever been seriously ill? If *Yes*, mention illness and duration** .....

    .....
16. **Have you ever met any accident?** .....
17. **What do you fear most?** .....
18. **Which career you wanted to adopt?** .....
19. **How religious are you?** **VERY / MODERATELY / NOT REALLY**
20. **Briefly describe yourself, i.e.**

    Strong Points:

Weak Points:

Concerns/ Problems

Duration of Concern

- **Few days**
- **Week**
- **Month**
- **Several Months**
- **Year**
- **More than a year**

Medical & Mental Health History

Any Physical Problems you are having. If yes, please specify **Yes** **No**

Counseling/Psychotherapy or Psychiatric medication in the past? **Yes** **No**

Substance use/ Smoking? **Yes** **No**

Psychologist/ Counselor's Remarks
Psychologist/Counselor: ……