

COUNSELING FORM

Name: _____ Reporting Date: _____

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

School: _____ Semester: _____ Semester wise GPA: _____

Is this subject (Academic Major) your first priority: Yes No

Religion: _____ Sect: _____

Home town: _____ Mother Tongue: _____ Residential Status: Hostelites /Day Scholar

Contact No: _____ E-mail: _____

Preferred Method of Contact

Phone Email Personal Presence

Referred by

Rector/Pro-Rector Self Administration
 Principal/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)

8. Any mishap/ trauma faced by you/ your family?
9. How many fast friends do you have?
10. What do you like most?
11. Have you ever been abroad?
12. Have you ever been seriously ill? If *Yes*, mention illness and duration
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13. Have you ever met any accident?
14. Which career would you like to adopt?
15. What do you fear most?
16. How religious are you? **VERY / MODERATELY / NOT REALLY**
17. 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

Mental Health History

- Counseling/Psychotherapy of Psychiatric medication in the past? Yes No
- Substance use/ Smoking? Yes No

Psychologist/ Counselor's Remarks
Psychologist/Counselor: