

Nanhua University Student Counseling Center

Psychological Counseling (test) Registration Form

Date: YY MM DD

Name		Department	Department	Year	Class
E-mail		Student number		Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address		Date of birth			
		Contact number			
Emergency contact person	(Relationship) :		Emergency contact number		
Purpose of counseling	<input type="checkbox"/> Counseling <input type="checkbox"/> Test				
Motivation of counseling	1. <input type="checkbox"/> Voluntarily ask for help 2. <input type="checkbox"/> Invite by counseling center 3. <input type="checkbox"/> Referral from drillmaster 4. <input type="checkbox"/> Referral from teacher _____ 5. <input type="checkbox"/> Classmate's introduction 6. <input type="checkbox"/> Course's requirement 7. <input type="checkbox"/> Other				
Expectation of counseling	What kind of help do you expect from this counseling (test)?				
Category of problem (Multiple selections acceptable)	1. <input type="checkbox"/> Self-exploration 2. <input type="checkbox"/> Family problem 3. <input type="checkbox"/> Interpersonal relationship problem 4. <input type="checkbox"/> Sentimental problem 5. <input type="checkbox"/> Career development 6. <input type="checkbox"/> Learning problem 7. <input type="checkbox"/> Emotional problem 8. <input type="checkbox"/> Mental situation 9. <input type="checkbox"/> Suicidal (autotomy) tendency 10. <input type="checkbox"/> Gender problem 11. <input type="checkbox"/> Economical problem 12. <input type="checkbox"/> Other				
Experience of counseling	1. Have you received relevant psychological services before?				
	<input type="checkbox"/> No <input type="checkbox"/> Yes (<input type="checkbox"/> School <input type="checkbox"/> Hospital <input type="checkbox"/> Community)				
Other situation	2. Have you received services from this center before?				
	<input type="checkbox"/> No <input type="checkbox"/> Yes (<input type="checkbox"/> Individual counseling <input type="checkbox"/> Test <input type="checkbox"/> Group counseling)				
Other situation	1.Mental situation				
	◎Do you have any history of mental illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know (Diagnostic symptoms)_____				
First counselor	◎Do you have mental illness currently? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know (Diagnostic symptoms)_____				
	2.Other				
First counselor		Tutor			