

Application Form for Individual Counseling, the Counseling

Section of Student Affairs Office, NKUHT

Date: DD : MM: YYYY:

Name		Sex		Date of birth	date month year	Contact Tel.	(home) (mobile phone)
Department	<input type="checkbox"/> university: department _____ class _____ grade _____ <input type="checkbox"/> postgraduate: department _____ class _____ grade _____ <input type="checkbox"/> college of continuing education: department _____ class _____ grade _____ <input type="checkbox"/> five-year program _____					Student No.	
						Marital status	<input type="checkbox"/> single <input type="checkbox"/> married <input type="checkbox"/> separated <input type="checkbox"/> divorced <input type="checkbox"/> other _____
Accommodation	<input type="checkbox"/> on campus		<input type="checkbox"/> dormitory _____ Qipu Building <input type="checkbox"/> dormitory _____ Jingcheng Building				
	<input type="checkbox"/> rented accommodation		Address				
	<input type="checkbox"/> others _____		E-mail				
Emergency contact		Relationship		Contact Tel.			
Reason for counseling	<input type="checkbox"/> self need <input type="checkbox"/> referred by classmates/friends _____ <input type="checkbox"/> referred by advisor _____ <input type="checkbox"/> referred by other teachers _____ <input type="checkbox"/> referred by military instructor _____ <input type="checkbox"/> assessment result <input type="checkbox"/> others _____ (please specify)						
Counseling issues (may check more than one) <input type="checkbox"/> family relationship <input type="checkbox"/> interpersonal relationship <input type="checkbox"/> emotional problem <input type="checkbox"/> study and schoolwork <input type="checkbox"/> self exploration <input type="checkbox"/> career exploration <input type="checkbox"/> life adjustment <input type="checkbox"/> others : _____ (Please specify)							
Tests you want to take(may check more than one) <input type="checkbox"/> No <input type="checkbox"/> Yes, please mark : <input type="checkbox"/> emotional test <input type="checkbox"/> test of interpersonal relationship <input type="checkbox"/> career test <input type="checkbox"/> personality test <input type="checkbox"/> others : _____ (Please specify)							
Pressure level in last 2 weeks Describe with point 0-10, 0 for “nearly none” and 10 for “too high pressure and can’t bear nearly” About _____ point (s)							
Thoughts about self harming within the last 2 weeks <input type="checkbox"/> I have not thought about hurting myself. <input type="checkbox"/> Yes, I have thoughts, but will not do it. <input type="checkbox"/> I want to hurt myself. <input type="checkbox"/> If any opportunity arises, I will actually hurt myself.							
Besides the counseling, other supports/aids I am seeking from: <input type="checkbox"/> parents <input type="checkbox"/> siblings <input type="checkbox"/> relatives <input type="checkbox"/> friends <input type="checkbox"/> companion/lover <input type="checkbox"/> teachers <input type="checkbox"/> other _____ (Please specify) <input type="checkbox"/> none, I’m by myself, seeking no others’ support.							

Appointing counselor	<input type="checkbox"/> No <input type="checkbox"/> Yes: Counselor_____	Any counseling experience with counselor before	<input type="checkbox"/> No <input type="checkbox"/> Yes: Counselor_____ <input type="checkbox"/> I am accepting treatment from another professional psychologist.
Family background	<p>1.Family members</p> <p>father <input type="checkbox"/>alive, <input type="checkbox"/>deceased , age_____ , career : _____</p> <p>mother <input type="checkbox"/>alive, <input type="checkbox"/>deceased , age_____ , career : _____</p> <p>siblings <input type="checkbox"/>No <input type="checkbox"/>Yes, I have_____sister(s) and ____brother(s), and I'm the_____ (sequence) child</p> <p>2.Martial status of parents</p> <p><input type="checkbox"/>live together <input type="checkbox"/>separated <input type="checkbox"/>divorced <input type="checkbox"/>other_____</p> <p>3. Family Atmosphere</p> <p>How do you think of your family atmosphere (describer with points 0-10: 0 for “really bad” and 10 for very good) about : _____point (s)</p> <p>4.History of mental disease of any family member?</p> <p>Has anyone in your family been diagnosed with a psychological disorder ?</p> <p><input type="checkbox"/>No <input type="checkbox"/>Yes, the diagnosis is _____ and he/she is my_____</p>		

Please fill in the time intervals proper for your counseling session. Please select **at least 5 intervals** for the convenience to make arrangement for you. Thank you.

Class Time		Monday	Tuesday	Wednesday	Thursday	Friday
1	8:10~9:00					
2	9:10~10:00					
3	10:20~11:10					
4	11:20~12:10					
5	12:20~13:10					
6	13:20~14:10					
7	14:20~15:10					
8	15:30~16:20					
9	16:30~17:20					
A	18:00~18:50					
B	19:00~19:50					
C	20:00~20:50					

Please submit to the counseling section of student affairs office on F2, administrative building in person upon completion. If no reply is received within 5 working days, please call (07)8060505 to 13302-13304 and ask for the counsel teacher Lin or teacher Wang. Thank you for your application.

amended on September, 2021