Centre for Disability Studies, Poojapura , Thiruvanthapuram

COUNSELING REGISTRATION FORM

Student's Name____________________________________Birth Date _________

Age_____ Standard________Home Telephone ___________________________

Mother's Name__________________________ Mobile Phone________________

Father's Name___________________________ Mobile Phone________________

Parent's Address____

Challenged as : Locomotor /Visual/ Hearing/Speech/ ADHD/Learning Disability/Dyslexia/Cerebral Palsy / Slow learner /Others

Reason(s) for referral:

Behavior	**At School**	**Relationships**	**Home concerns**
____worried	___homework notcomplete	___bullying	___fighting
____depressed	___low marks	___difficulty in making friends	___illness
____eating disorder	___sleeping in class/always tired	___poor social skills	___parents divorced/separated
____hyper	___sudden change in marks	__dishonest	___suspected substance abuse
____Inattentive	___frequently absent	__ likes to be alone	___lying
____shy			
____low self esteem			
____aggressive			

Any other Concerns

____

Referred By___________________________________

Preferred date and time to visit the centre : _________am/pm

Place and Date   Signature