

**PARENTS' COUNSELLING FORM**

Student Name	
Age	
Class	
Type of Disability	
Session Duration	
Child Relation with Respondent: Father/Mother _____	
Date	

**Counseling Needs (Please be Specific)**

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**Behavioral Observations of the Respondent / Parents**

<b>Appearance</b>	Hygiene (Clean) <input type="checkbox"/>	Not Well Cleaned <input type="checkbox"/>	Dirty <input type="checkbox"/>	
<b>Attention</b>	Normal <input type="checkbox"/>	In-Attentive <input type="checkbox"/>	Confused <input type="checkbox"/>	
<b>Thoughts</b>	Goal Directed <input type="checkbox"/>	Circumstantial <input type="checkbox"/>	Loose Association <input type="checkbox"/>	
<b>Attitude</b>	Co-operative <input type="checkbox"/>	Uninterested <input type="checkbox"/>	Reluctant <input type="checkbox"/>	Irritable <input type="checkbox"/>
<b>Mood</b>	Normal <input type="checkbox"/>	Anxious <input type="checkbox"/>	Depressed <input type="checkbox"/>	Euphoric <input type="checkbox"/>

**Objective(s)**

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**Key Points of Counseling Session:**

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**Therapeutic / Intervention Plan**

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**Follow up Session (Please Specify the next session date)**

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Parents' Signature\_\_\_\_\_  
Psychologist's Signature