Davao de Oro State College

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07	00	04.01.2026	1 of 1

COUNSELING NOTE

Name: _____ **Age:** _____ **Sex:** _____
Yr. & Sec.: _____ **Mobile No.:** _____ **Email address:** _____
Date of Counseling: _____ **Time Started:** _____ **Time Ended:** _____

Based on the Initial Intake Interview Form.

Reason for Referral: _____

Components	Facets	Urgency			Remarks
		H	M	N	
Problem Presented	Personal				
	Family				
	Grief				
	Interpersonal				
	Academics				
	Future Career				
	Others				
Behavioral Observations	Motor				
	Cognitive				
	Affect				

*Legend: **H**-high, **M**-mild, **N**-not applicable*

Goals: _____

Intervention: _____

The counseling session is:

☐ Closed/Terminated ☐ Needs follow up On:_____ ☐ In need of referral to a:
- ☐ Psychologist/Psychiatrist
- ☐ Medical Doctor
- ☐ Occupational Therapist

STUDENT'S NAME & SIGNATURE **SCHOOL COUNSELOR'S NAME AND SIGNATURE**