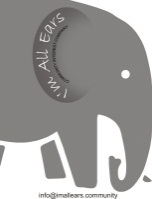
**I’m all ears**

**ASSESSMENT FORM**

Please provide the following information and answer the questions below. Please note; Information you provide here is protected as confidential information as detailed within the counselling contract, by signing the form you are agreeing to us keeping this form in a secure place and to contacting you via the given personal information. Please Fill out this form and bring it to your first session.

**GENERAL INFORMATION**

|  |
| --- |
| **Name:**  **Address:**  **DOB: Age: Male/Female/Other**  **Ethnicity:**  **Home Phone: Mobile:**  **Email:**  (email is not considered to be a confidential)  **Contact preference: email/ text/ voice call/ voice message**  (please delete those not suitable)  **Name of Parent/Guardian if under 18 years:** |

|  |
| --- |
| **Do you have children?**  **Do you have any other dependents?** |

|  |
| --- |
| **Name of Doctor:**  **Address:**  **Phone number: Date last seen:**  **Current Health:** |
| **Prescribed Medication:**  **Previous Health:**  **Have you had any previous therapy, or attended any support groups?** |

|  |
| --- |
| **Please highlight those things that have brought you here today:**   1. **Depression** 2. **Relationships** 3. **Bereavement** 4. **Low mood** 5. **Anxiety and Worry & fears** 6. **Traumatic incident** 7. **Addiction** 8. **Life changing events** 9. **Illness of you or other** 10. **Finding it hard to cope** 11. **Other: please do explain other in the space below:** |

|  |
| --- |
| **Are you or have you ever experienced overwhelming sadness, grief or depression?**  **Please tell me a little about it?** (When? For how long?)  A**re you or have you previously experienced anxiety, panic attacks or have any phobias?**  **Please tell me a little about it?** (when? For how long?) |
| **Is there anything else you feel we should know, or that you are concerned about?** |

Client name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_