**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**

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| **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:** |

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

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| **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?** |

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| **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:**
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| **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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_