PURE-MINDS

COUNSELLING CLIENT AGREEMENT, INTAKE CONSULTATION AND ASSESSMENT

Counselling is a confidential service, offered in accordance with the BACP Ethical Framework for Counselling Professions (2016) / (2018) or UKCP Ethical Principles and Code of Professional Conduct (2009). There are however circumstances where I would be required to breach confidentiality (listed below).

- Disclosure of unreported abuse on a young person below the age of 18, or on a vulnerable adult.
- Risk of significant harm to self or others / act of serious harm to self or others.
- Suspected involvement in an act of terrorism, trafficking or money laundering.
- Liaison with health professionals as part of a coordinated health care package.
- Court Order
- Public interest to disclose. Public interest is the general welfare and rights of the public that should be recognised, protected and advanced. Disclosures, based on the common law, are made when essential to prevent a serious and imminent threat to public health.

If possible and appropriate, any breach of confidentiality would be discussed with you prior to action being taken. I confirm that I have read and agree to the terms of confidentiality above.

Signature of Client/Parent/Guardian: .....

Date: .....

Please note the Information you provide here is protected as confidential. This information is for the counsellor only if you are assessed as suitable for counselling.

GENERAL INFORMATION

Client Name: ..... Age: .....

Date of birth: ..... Gender: Male / Female / Non-Binary / Trans / Agender

Emergency Contact Name: ..... Number: .....

Address: .....

Mobile: .....

.....

Home phone: .....

Email: .....

(email not considered confidential)

May I leave a message? Yes / No

May I send you an email with any resources? Yes / No

Ethnicity: .....

Religion: .....

Doctor: .....

Address: .....

Referred / self referral?.....

Date of visit: .....

ABOUT YOU

Name of School / (if in education) .....

Do / did you like school? Yes / No

Have you ever experience any kind of bullying? Yes / No

Status: Single / Relationship / Separated / Separated / Married / Divorced

.....

Do you have a relationship with your parents?

Years together: .....

.....

Years separated: .....

Dependents: .....

Siblings: .....

On the scale of 1-10 how would you rate your relationships?

To self: .....

Family: .....

Friends: .....

Partners: .....

Have you experienced any significant life changes or stressful events?

.....

.....

Who currently lives in your household?

FAMILY AND PERSONAL MENTAL HEALTH HISTORY

Alcohol/Substance misuse: Yes / No

Do you drink alcohol more than once a week? Yes / No

Do you engage in drug use? Yes / No

Do you feel that substance misuse or addiction is an area of concern for you? Yes / No

If yes please explain, including which substance is used: .....

Anxiety, panic attacks or phobias: Yes / No

Depression: Yes / No

Domestic abuse: Yes / No

Eating Disorders/ disordered eating (including obesity): Yes / No

Obsessive Compulsive Behaviour: Yes / No
Schizophrenia / Bipolar: Yes / No
Significant attempts to harm self: Yes / No
Autism spectrum / ADHD / ADD / Bipolar / ODD: Yes / No
Have you experienced physical or emotional abuse: Yes / No

Any family history of the above and which member of the family member?

.....

HEALTH HISTORY

Have you previously receieved any mental health interventions
(Counselling, Psychotherapy, Psychiatric services, ECT, CBT, Anxiety support groups?)

Yes / No (if yes please state details below): when, where, did you find them helpful?

.....
.....
.....
.....

Have you ever been prescribed psychiatric medication?
Yes / No (if yes please list an indicate which medication below:

.....

Are you currently taking any prescription medication?
Yes / No (if yes please list and indicate which medication below and what for:

.....

Please rate the following on a scale of 1-10 (1 being the lowest, 10 being highest)

Physical health .....
Please list any specific problems you are currently experiencing:

.....

Sleeping habits .....
Please list any specific problems you are currently experiencing:

.....

How many time a week do you generally exercise and what types of exercise:

.....

Are any physical characteristics of body image a concern?

.....

EMPLOYMENT

Are you currently employed? Yes / No
Do you enjoy your work? Yes / No

Is there anything stressful about your current work?

.....

Are you a carer? Yes / No
If yes do you receieve any support? Yes / No

ADDITIONAL INFORMATION

Anything else you feel we should know, or that you are concerned about? Reason for attending counselling?

.....

.....

What do you consider to be some of your strengths?

.....

.....

What do you consider to be some of your limitations?

.....

.....

Goals for therapy

.....

.....

CONFIDENTIALITY

Everything we discuss in our sessions will be treated completely private and between you and me as your therapist. There are boundaries and limits to confidentiality and in certain cases confidentiality may need to be broken; if in my opinion as the therapist, you are thought to be at risk, I as the therapist have a duty of care and am required to report this to either my supervisor and/or the authorities.

RISKS

- serious danger to yourself or to anyone else.
- at serious risk of serious harm or knowledge of such to yourself or anyone else.
- involved in or any knowledge of; an act of terrorism or money laundering.
- risk by being involved in drugs trafficking.
- risk of being involved in behaviours that may lead to harm or neglect to children and vulnerable adults.

CONSENT TO RECORD

As a practice to best support and facilitate the client's progression and support the counsellor's self-evaluation, voice recordings of clinical sessions can be obtained. All recordings will be anonymised to maintain confidentiality and deleted after use. Please tick below to confirm your consent for recordings to be taken during your/ the client's sessions. The client will always be consulted before a recording is made and the client has the right to refuse that the session be recorded:

Voice recording consent given Yes / No

WHAT THE THERAPIST OFFERS

A Person Centred, Psychodynamic and/or Cognitive Behavioural Therapeutic support. This gives you empowerment to discover solutions to problems in a supportive environment and to look at how past events may have influence how you think and feel in the present, whilst gathering tools and strategies to use when overcoming your own barriers to how you think and feel.

SUPERVISION AND CONFIDENTIALITY

It is a requirement of the BACP and UKCP for counsellors to receive regular supervision ensuring high standards of professional practice are maintained. If presented during supervision, a client code or initials will be used to ensure your confidentiality is maintained. Any notes made in relation to your sessions are securely kept for 7 years, then destroyed.

YOUR AVAILABILITY FOR COUNSELLING:

Monday ..... Tuesday ..... Wednesday .....

Thursday ..... Friday ..... Saturday .....

Ageed Fee:

Payments to be made no later than **24 hours** prior to the booked start time of the session to hold your appointment, failure to do so could result in a cancelled session.

Cancellation of session within **24 hours** or failure to attend a scheduled session: **Full fee (will be claimed)**

Name:..... Signature.....(Signature of Client/Parent/Guardian:)

For office use:

Client Code: .....

JAMES.LEVERINGTON@PURE-MINDS.CO.UK | +44 7801 052657 | BACP REGISTERED