

**Your Stepping Stones**

**Pre-Counselling Assessment Form**

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| **Personal details** |
| Full Name |
| Preferred name |
| D O B |
| Address |
| Contact number |
| Happy for a message to be left - Y/N |
| Email |
| Emergency contact details |
| * Name |
| * Relationship |
| * Contact number |
|  |
| **Medical details** |
| GP Name |
| Address |
| Current health problems & medication taken |
| Are you at danger of harm to yourselves or others? If so please state |
| Do you have any mental health issues – if so please list them |
| Any disabilities? I can have access to a different venue if you have movability disabilities |
| Are you at risk from alcohol or substance abuse? |
| Do you self-harm? If so when was the last time? |
| Any other information you would like me to be aware of? |
| **Mental Health Questionnaire** |
| Do you have suicidal thought? If yes when was the last time you felt that way? |
| Have you had counselling before? If so, what worked and what didn’t? |
|  |
| **Goals** |
| What made you come to therapy? |
| What goals would you like to achieve ? |

Please return to the below email address before your first session

Thelm@yoursteppingstones.co.uk

Many thanks

Thelm