Reframe Your Story

THERAPY with Debbie

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Client Information form

Client Details

First Name: .... Surname: ....

Home Address: ....

....

Age: .... DoB: .... Sex/Gender: ....

(if applicable) Phone: .... Email: ....

Parent/Gaurdian/Next of Kin Contact Details

Parent/guardian/next of kin: ....

Your relationship to the client: ....

Phone: .... Email: ....

Name of any other legal guardians: ....

Relationship to the child: ....

Phone: .... Email: ....

Additional Information Pertaining to Your Client

Ethnicity: .... Religion: (optional) ....

GP: .... Phone: ....

Address: ....

....

Medical history/diagnosis: ....

....

Allergies: ....

Current school/employer: ....

Areas of Concern - Check List

	Never	Sometime	Often	Always
Finds It hard to go to sleep or stay asleep.	☐	☐	☐	☐
Enjoys food and eat well throughout the day.	☐	☐	☐	☐
Good at making friends and keeping friends.	☐	☐	☐	☐
Good relationships at home.	☐	☐	☐	☐
Good relationships at school.	☐	☐	☐	☐
Gets frustrated and angry.	☐	☐	☐	☐
Hurts other people.	☐	☐	☐	☐
Feels anxious, worried or stressed.	☐	☐	☐	☐
Able to cope when things go wrong.	☐	☐	☐	☐
Thinks about hurting themselves.	☐	☐	☐	☐

Any other relevant information (eg. loss/bereavement): ....

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