



Debbie Strafford Counselling

Reframe Your Story

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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:

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Medical history/diagnosis:

Allergies:

Current school/employer:

Areas of Concern - Check List

	Never	Sometimes	Always	N/A
Finds it hard to go to sleep or stay asleep.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Enjoys food and eats well throughout the day.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Good at making friends and keeping friends.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Good relationships at home.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Good relationships at school.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gets frustrated and angry.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hurts others.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feels anxious, worried or stressed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to cope when things go wrong.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thinks about hurting themselves.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

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