Holistic wellbeing counselling
Client Information form

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Personal details

Full name	
Date of birth	
Ethnicity	
Gender	
Phone number	
Email	
Address	
Job	
Relationship	
Number of children	

Who are you currently living with?

Are you currently on any medication? Yes/ No
If yes, please specify your medication.

Name of your GP:

Do you give me consent to contact your doctor if needed? Yes/ No

Do you use any tobacco? Yes/ No
If yes, please specify how often and how long have you been using it?

Do you use any controlled substances? Yes/ No
If yes, please specify how often and how long have you been using it?

Do you use alcohol? Yes/ No
If yes, please specify how often and how long have you been using it?

Current Symptoms

	Please answer Yes/ No Please feel free to add extra comment(s), if needed
Depressed mood	
Excessive worry	
Anxiety	
Impulsivity	
Sleep pattern disturbance	If yes, specify.
Concentration/ forgetfulness	
Suspicious	
Crying spells	
Racing thoughts	
Unable to enjoy activities	
Loneliness/ Hopelessness	
Hallucination	
Fatigue	
Change in appetite	
Suicide attempts	
Suicide plans	
Recent Suicidal thoughts	
Increase risky behaviour	
Difficulty in social activity	
Difficulty expressing feelings	
Difficulty in decision making	
Anger problem	
Attention deficiency	
Shy or sensitive	

Very sensitive to any criticism	

If you would like to add any extra comments, please feel free to add it here.

Past Counselling history

Have you been to counselling before? Yes/ No
If yes, please specify time and the reason for counselling.

What did you find the most helpful in therapy?

What did you find the least helpful in therapy?

Emergency contact:

Full Name	
Phone Email	
Relationship	

Signature Date: