CONFIDENTIAL INITIAL ASSESSMENT FORM Ref:

Client Details: Mr/Mrs/Miss/Ms (Please delete as applicable)

Surname ..………………………………………….............................

First Name(s) .........………………………………………….......................

Date of Birth .........………………………………………….......................

Address ........……………………….…….…………..........................

Postcode …………………....... Telephone No ………..………..........

Brief Description as to why you feel counselling may help you at this time:

How did you hear about Audite Counselling?

**Medical History**

Physical:

Psychiatric:

Name and Address of GP ………………………………………..............................

Please give the name and telephone number of someone we could contact in case of an emergency:

……………………………………………………………………………….............................

Have you attended counselling before? YES NO

Please describe any significant life events:

Any other information you feel might be helpful, including any special needs we should know about:

Please tick here if you are currently a Counselling Student

Please tick below when you are regularly available for appointments:

|  |  |  |
| --- | --- | --- |
| Day | Times | Please tick |
|  |  |  |
| Monday | 4pm – 8pm |  |
| Tuesday | 4pm – 8pm |  |
| Wednesday | 4pm – 8pm |  |
| Thursday | 4pm – 8pm |  |
| Friday | 4pm – 8pm |  |
| Saturday | 9am – 12Noon |  |

Please tick as many spaces as you can so that you can be offered an appointment as soon as possible.

Signed ………………………………………… Date …………………..