**CLIENT INFORMATION**

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| Title |  |
| Full Name(s) |  |
| Full Address |  |
| Telephone |  |
| Email |  |
| Date of Birth |  |
| Gender |  |
| Nationality |  |
| Ethnic Origin |  |
| Religion |  |
| Adoption |  |
| Work Status and Employment (Job Title, type of work, etc.). |  |
| Relationship Status e.g. single, in a relationship, married, civil partnership, living together, separated, divorced, widowed, etc. |  |
| Sexual Orientation |  |
| Relatives: Parents, step parents, siblings, partner’s family, etc. |  |
| Dependants – e.g. children, step children (how many, gender and ages), elderly relatives, etc. |  |
| Physical disabilities |  |
| Physical or Mental Health Problems |  |
| Psychiatric History |  |
| Registered with GP (please provide doctors’ name, surgery practice name, address and telephone number. |  |
| Medication (any that you are taking in as much detail as possible with name and amount of mg). |  |
| Addictions e.g. drugs, alcohol, smoking, gambling, sex, porn, shopping, etc. |  |
| Other/Historical Issues |  |
| Abuse (past and present - physical, sexual, mental, emotional, neglect) |  |
| Any past or present thoughts of suicide? |  |
|  |  |
| Next of Kin/Emergency Contact details – please include: name, address, telephone, email and their relationship to you. |  |
| Presenting Issue(s) – Please give as much detail as possible. |  |
| Have you had any therapy/counselling previously?  How long for?  Reason for ending therapy? |  |
| What would you like to achieve from our therapy sessions? |  |
| Date of Referral  Source of Referral  Agreed number of sessions  Fees agreed  Date of First Session  Date of Last Session  Reasons for ending therapy |  |
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