Client Information

Mr/Mrs/Miss/Ms/Other ___________________________ Last name __________________________

Name you like to be called ____

Date of birth____

Address ____

____

Telephone Numbers/Contact Details (* If appropriate to contact you on them Y/N)

Home________________________________(Y/N) Mobile _____________________________(Y/N)

Email____(Y/N)

Best Contact Method (Usual) ______________________

Emergency Contact ___________________ Name _____________________Relationship_____________

Medical Information

Name/Address of Doctor Surgery____

____

Name of GP________________________________GP Number__________________________________

Current Medication (Prescribed or Self-Medicated)______________________________________

____

____

Any previous or on-going illness____

____

____

Family Information

Significant Other's Name____________________ Relationship to you___________________________

Details of Children (Names/Ages whether living with you or not) ______________________________

____

____

Parents ____

____

Siblings

____

____

What is your relationship like with family and friends?_______________________________________

____

Employment Information

Current Employment Status (Employed Full time, Part Time, Unemployed, Unable to attend, Other)

____

Occupation ____

Therapy goals

What do you feel is you main problem area? ______________________________________

____

What are your current symptoms and/or difficulties?_________________________________

____

What has lead you to seek help at this stage?______________________________________

____

When would you say the problem first began?_____________________________________

____

What are your hopes and expectations from attending this therapy? ___________________________

____

____

What are you long term goals?____

____

What do you expect to change after your treatment has completed?___________________________

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