CT Client Reference: ……. (office use only)

ASSESSMENT INTERVIEW FORM

(October 2017)

Counselling Together

In Association with LEAF
Registered Charity No. 1108406

This assessment form is to enable the counsellor to gain a better understanding of how to help you. Please take time to answer all the questions as honestly as possible and bring your completed form to your assessment session.

Name:	**Date Of Birth:**
Address:	
Tel. Number Home:	**Tel. Number work:**
Tel. Number Mobile:	**E-mail address:**
Can a counsellor leave a message at any one of these contact points?	
Marital status, please circle: Married / Single / Engaged / Divorced / Widowed	
Years married:	**Years divorced:** **Years widowed:**
Occupation:	
GP Name and Address:	
Telephone number of GP:	
How did you find out about our counselling service?	
When would you be available (days & times) for counselling and are you able to travel to the counselling room? (i.e. have you a car or other means to travel?)	
Have you the means to pay the required counselling fees over this period of time? (Fees are normally £40 for individual sessions and £60 for couples sessions, but there may be opportunity for negotiation depending on financial circumstances.)	
With thanks to the support of local churches, we have a small number of Bursary places available for those in financial need (e.g. out of work and receiving benefits). Would you like to apply for one of these places, this may involve a wait for a funded place to be available?	
Once you have completed the remainder of the form pleas sign and date it here	
Signed:	**Date:**

Counselling Together have the highest respect for your privacy and want to ensure you that we will not distribute, sell, lease, or share your personal information to any third party, unless we have reason to believe that disclosing this information is reasonably necessary to comply with the law. Counselling Together complies with the Data Protection Act of 1998 in the collection, processing, holding and transmitting of your personal information. Only in the case that your request concerns our services will we gather and secure your personal information. This will be used to contact you, to understand your needs and to improve our services.

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Your childhood (brief description – good/bad memories):
Have you any history of church attendance and do you want to say anything about your spiritual beliefs including none?
Any previous psychiatric treatment or counselling? When and for what and how long was the therapy and why was it ended? **Was this helpful and say why?**
Have you any objection to me writing to your GP when you start your counselling sessions? (if yes, then say why you object):
Have you any objection to me speaking by telephone to your GP if it becomes necessary at any time during the counselling?
Medical problems/history:
If you are receiving any medical treatment or taking medication prescribed by your GP please give the details e.g. name and dosage:
MEDICATION, SUBSTANCES AND MENTAL HEALTH: *In order to ensure their safety, Clients should reveal if they are taking any medication or substances or have a history of any mental health conditions at the commencement of counselling. If the Client does not disclose information which later proves to be significant in the counselling work this may lead to the Counsellor needing to speak to the Client's GP or other appropriate professional or services. Clients should inform their Counsellor if there is any change in their medication or substance intake or their mental health at any time whilst the counselling arrangement is in effect.*
What would you say is the condition of your overall health?
Have you ever self harmed? If yes, say how:
Have you ever had suicidal thoughts? If so, when and did you create a plan about how to take your own life?
Why are you seeking counselling now, rather than any other time i.e. what are the recent circumstances that have led to your decision to apply?

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Please indicate below which of the following apply to you now:

	Yes	No		Yes	No		Yes	No		Yes	No
Headaches	❑	❑	**Nightmares**	❑	❑	**Palpatations**	❑	❑	**Anxiety**	❑	❑
Fatigue	❑	❑	**Loneliness**	❑	❑	**Tremors**	❑	❑	**Guilt**	❑	❑
Tension	❑	❑	**Isolated**	❑	❑	**Smoking**	❑	❑	**Sexual problems**	❑	❑
Insomnia	❑	❑	**Dizziness**	❑	❑	**Vomiting**	❑	❑	**Suicidal thoughts**	❑	❑
Shyness	❑	❑	**Irritability**	❑	❑	**Eating disorders**	❑	❑	**Bowel disturbances**	❑	❑
Withdrawn	❑	❑	**Alcoholism**	❑	❑	**Depression**	❑	❑	**Appetite Loss**	❑	❑
Panic Attacks	❑	❑	**Fainting**	❑	❑	**Stomach trouble**	❑	❑	**Financial problems**	❑	❑
Difficulty in making friends	❑	❑	**Indecisiveness**	❑	❑	**Drug dependancy**	❑	❑	**Weight loss**	❑	❑
Anger	❑	❑	**Bad home conditions**	❑	❑	**Difficulty in keeping a job**	❑	❑	**Any other difficult emotion?**		
Apathetic	❑	❑							**……**		

Do you have any pastoral support from a church or a friend?

Social Life/Hobbies:

Please indicate the nature of your problem and when it began:

How does the problem restrict you in living how you want to?

What changes would you like to make in your life?

How do you think counselling can help you i.e. what are your expectations of counselling?

Counselling may take around 6 – 12 months or more of weekly sessions. Do you feel able to maintain such a long term commitment?

Once Completed please Initial here: **Date:**

And please sign and date Page 1