|  |  |
| --- | --- |
| **Personal Information** |  |
| **Name(s)** |   |
| **Date of birth** |   |
| **Telephone** |   |
| **Email** |   |
| **Method of referral** |  |

|  |
| --- |
| **Address** |
| **House number/name:** |
| **Street:** |
| **City: Postcode:** |

|  |
| --- |
| **Details of your GP** |
| **GP name:** |
| **GP address:** |
| **GP tel no:** |

|  |
| --- |
| **Emergency Contact Person** |
| **Name and Relationship:** |
| **Tel no:** |

Have you had any serious illnesses I should be aware of?

Have you had previous psychiatric or psychological treatment or counselling?

Are you on any medication that I should know about, that might impact our work together, or that is related to the issues that have brought you to therapy?

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Client signature and date**

**I have read and understood the associated Terms of Engagement and Privacy Policy and give my consent for my personal data to be held and used for the purpose of working together. I understand that I may withdraw my consent at any time by giving notice of such withdrawal in writing.**