Client Contact Details

|  |  |
| --- | --- |
| Name |  |
| Address |  |
| Date of Birth |  |
| Contact Number |  |
| Email |  |
| GP Surgery and tel. |  |
| Emergency Contact | |  |  |  | | --- | --- | --- | | Name | Relationship | Number | |  |  |  | | Is your contact therapy aware | |  | |
| Date of first contact |  |

|  |  |
| --- | --- |
| Referred by |  |
| Previous counselling  (type if known) |  |
| Any other MH support? |  |
| Diagnosed conditions |  |
| Prescription medication |  |
| Any other information |  |

|  |  |  |
| --- | --- | --- |
| Client Code | | |
| M/F/Other (X/Y/Z) | Age | Reference |
|  |  |  |