**THERAPY CENTRE SERVICES**

**1st Session Assessment Form**

**CLIENT DETAILS**

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| --- | --- |
| **Client Name :** |  |
| **Date of Referral :** |  |
| **Referral reference :** | **IINN-001** |

**GENERAL MENTAL HEALTH ASSESSMENT**

**Please specify main presenting issue:**

|  |  |  |
| --- | --- | --- |
| **Level A** | **Level B** | **Level C** |
| Anxiety (generalised) | Abortion | Addictions |
| Bereavement | Anger | Adoption |
| Bullying | Cancer | Attachment disorder |
| Depression (low level / no risk) | Child abuse | Body dysmorphia |
| Divorce | Complex grief | Dementia |
| Family issues | Domestic abuse | Disassociation |
| Feeling sad / SAD | Miscarriage | Eating disorders |
| Loneliness | Health anxiety | OCD |
| Relationship issues | Physical abuse | PTSD |
| Redundancy | Postnatal depression | Paranoia |
| Self confidence / self esteem | Self harm / suicidal thoughts | Personality disorders |
| Stress | Sexuality (coming to terms with) | Phobias |
| Work related stress | Trauma | Sexuality (gender identity / sexual preference) |
|  |  | Schizophrenia |

**Can you confirm if you are experiencing, or have been formally assessed or diagnosed with any of the following;**

|  |  |  |
| --- | --- | --- |
| Anxiety | Hypomania / Mania | Personality Disorders |
| Bi-polar | Gender identity | Psychosis |
| Body Dysmorphia | Paranoia | Schizophrenia |
| Dependency (drug / alcohol) | PTSD | Other : (please specify) |

**RISK ASSESSMENT**

Please select if you have previously attempted suicide, or have self-harmed Yes / No

Please select if you are experiencing suicidal ideations or feelings of wanting to self-harm Yes / No

**WORK RELATED ASSESSMENT**

Have you had any time off sick from work over the last 6 months? Yes / No

If so, how many days?

Can you confirm if these were due to work or personal related issues / mental health?

On a scale of 1-5 (1 being not at all and 5 being all the time) can you confirm if these issues have prevented you from concentrating on your work?

1 2 3 4 5

Please can you confirm if you have had any counselling previously, and if so provide details.

**RECOMMENDATION GIVEN**

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| --- |
|  |

**Date referred to Employer :**

**Outcome (Number of sessions authorised) :**