**THERAPY CENTRE SERVICES**

**Interim Session Report**

**CLIENT DETAILS**

|  |  |
| --- | --- |
| **Client Name :** |  |
| **Date of Referral :** |  |
| **Referral reference :** | **TCS Office use only** |

**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 |

**WORK RELATED ASSESSMENT**

Is the client currently attending work Yes / No

If no, how many days has the client been signed off work in the last 30 days?

**RISK ASSESSMENT**

Please select if the client has previous attempted suicide, or self-harmed?

Y / N

Please select if the client is currently experiencing suicidal ideations or feelings of wanting to self harm

Y / N

**MID WAY REVIEW**

Number of sessions to date :

Number of sessions authorised remaining :

**Additional information:**

|  |
| --- |
| **Presenting issues :** **Therapy Focus** (what have been the main focuses of the sessions together so far)1.2.3.**Signposting/Tools/Resources discussed:****Information regarding clinical recommendation for additional sessions:****Additional information :**  |
| **How many additional sessions are requested :** |  |

|  |  |
| --- | --- |
| **Date sent to client for authorisation :** |  |
| **Outcome :** |  |