**THERAPY CENTRE SERVICES**

**Initial Assessment Report**

**CLIENT DETAILS Date of Birth :**

|  |  |
| --- | --- |
| **Client Name :** |  |
| **Client full address (incl postcode)** |  |
| **Date of incident :** |  |
| **Date of 1st session:** |  |
| **Referral reference :** | **TCS Office use only** |

**CONTRACTING**

Confirmation that Statement of Understanding was agreed with client

Confirmation that Reports are provided after initial and final sessions

Confirmed with client that we inform the referrer any appointments DNA’d

and the reason for the session not attended.

**Report prepared and submitted by**

**Lucy Johnson**

Director

Therapy Centre Services

MBACP Registered (00796975)

Text, logo, company name

Description automatically generated

Date of Report :

**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

If yes, please provide details :

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

If yes, please provide details :

**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;

1. Work issues
2. Personal related issues

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**

|  |
| --- |
| **First session review** (summarise initial session, how you worked with your client and how the remaining sessions will be used) **Please provide comprehensive information under each heading below;**   1. **What has brought the client to counselling? What is the client’s understanding of the referral and what do they hope to get out of the sessions together** 2. **Presenting issue(s)** 3. **Current difficulties / impact issues are having on the client’s level of functioning** 4. **Thoughts / feelings / emotions currently experienced** 5. **What will sessions focus on, what is the desired outcome for the client, how will you work together towards these outcomes**     **Any other information :**  GP / Medication / other support being accessed  Any further information from the initial session |

**Date referred to Referrer :**

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

**Next session booked:**