**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)



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 accessedAny further information from the initial session |

**Date referred to Referrer :**

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

**Next session booked:**