**THERAPY CENTRE SERVICES**

**Final Session 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 |

**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?

**FINAL SESSION REPORT**

|  |  |
| --- | --- |
| **Sessions overview**   1. **What brought the client to counselling? What was the client’s understanding of the referral and what did you agree as the focus for the sessions together** 2. **Presenting issue(s) at the start and end of therapy** 3. **What difficulties / issues are remaining on the client’s level of functioning** 4. **Thoughts / feelings / emotions currently being experienced** | |
| **Scaling: Using 0 (worse) – 10 (better) scaling please record where the client would place themselves.** | |
| Start of counselling score: |  |
| End of counselling score : |  |
| **Is the client currently experiencing suicidial ideations? (0 – no suicidal ideations – 5 plans are in place)** | 0 1 2 3 4 5 |
| **What did the sessions focus on, what was the desired outcome for the client at the start of therapy, and how did you work together towards these outcomes. (**Please provide a comprehensive summary of the therapy focus and outcomes and any signposting / additional support required) |  |
| **Any other comments :** |  |