**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)



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 :** |  |