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**Initial Session Summary**

**Complete following the initial session of counselling.**

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| --- | --- |
| **Employee Details** | |
| Employee Name | Click here to enter text. |
| Employee Reference | Click here to enter text. |
| Date of First Session | Click here to enter a date. |
| Provider Name & Name of Counsellor | Click here to enter text. |
| Clinical assessment scores. | GAD7 Click here to enter text. |
| PHQ9 Click here to enter text. |
| HADS Click here to enter text. |
| Any perceived barriers to the provision of support | Click here to enter text. |
| Signature of Counsellor | Signature:  Date: Click here to enter a date. |

On completion of this form please ensure a copy is emailed to [Think.Well@staffordshire.gov.uk](mailto:Think.Well@staffordshire.gov.uk)