**THERAPY CENTRE SERVICES**

**Initial Assessment Report**

**CLIENT DETAILS**

|  |  |
| --- | --- |
| **Client Name :** |  |
| **Date of Initial 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.

**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) |

**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 you are currently experiencing;

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.

Please can you confirm how you would rate the support you are receiving from your employer in relation to your current situation (1 being poor – 5 being excellent)

1 2 3 4 5

Please confirm if there is any additional support you require from your Employer, or what other support you feel you require to enable to you to remain at work, or return to work if you are currently signed off from work.

**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 :

**Risk Level :** 0 1 2 3 4 5

(Please note Risk Level 3 and above will be notified to the employer

**RECOMMENDATION GIVEN**

|  |
| --- |
| **First session review** (summarise initial session, how you worked with your client and how the remaining sessions will be used)**Therapy Focus** (what are the intended main focuses of the sessions together)1.2.3.**Any other information :** |

**GAD / PHQ (this is optional and not a ‘requirement’ however if the client completes a GAD / PHQ assessment and agrees for the scores to be included in their report please provide the scores below);**

|  |  |
| --- | --- |
| **GAD** |  |
| **PHQ** |  |

**Date referred to Employer :**

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