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| **Individuals Details:** |
| **SS Number:** | OFFICE USE ONLY | **Email Address:** |  |
| **Full Name:** |  | **Tel No:** |  |

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| --- | --- | --- | --- |
| **Assessment completed****by:** |  | **Date:** |  |

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| **BWS Contact** | OFFICE USE ONLY |

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| **Assessment Score**  |  Scored out of 50  |
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| **History of circumstances leading to the initial assessment including current feelings, motivation levels, anxieties and any other coping difficulties:** | On a scale of 1-10 with 10 being very happy. How are you feeling? Notes: | Score |
| **History of any mental health conditions\*:** | Have you ever intentionally hurt yourself?  |
| **Any current medication, treatment or mental health specialist involved in client’s care?** | Notes:  |
| **What are you looking to get out of counselling sessions? What is the desired outcome?** | Notes:  |
| **How do you sleep? Disturbed/solid night’s sleep? On average, how many hours do you sleep?** | On a scale of 1-10 with 10 being completely satisfied. How well do you sleep?Notes: | Score |
| **Please describe your relationship with food, including any cravings, under or over-eating or eating patterns in relation to mood etc.?** | On a scale of 1-10 with 10 being very often. How often do you have regular meals?Notes: | Score |
| **Are you motivated to get ready in the morning?** | On a scale of 1-10 with 10 being very motivated. How motivated are you to get ready in the morning?Notes: | Score |
| **How often do you interact with friends, family and colleagues? (Text, email, call or face to face?)** | On a scale of 1-10 with 10 being very often. How often do you communicate with your social groups?Notes: | Score |
|  |
| **Observations** | **General informal observations:** | **YES** | **NO** |
|  | Did the client display difficulties expressing or understanding verbal communication? |  |  |
|  | Was the speech clear and fully intelligible? |  |  |
|  | Was the speech observed to be normal in content, normal in rate and normal in volume?  |  |  |
|  | Did the client remain on the call for the duration of the assessment without any interruptions?  |  |  |
|  | Did the client have the ability to show thought and reason?  |  |  |
|  | Did the client require prompting during the assessment? |  |  |
|  | Did the client interact and engage well with the assessor? |  |  |
|  |
|  | **Mental State observations:** | **YES** | **NO** |
|  | Did the client have a good understanding of feelings and anxieties? |  |  |
|  | Could the client convey information logically and lucidly?  |  |  |
|  | Did the client report any thoughts of suicide or self-harm?  |  |  |
|  | Did the client appear to remain calm, relaxed and of stable mood?  |  |  |
|  | Did the client demonstrate good cognition and an understanding of the referral process |  |  |
|  | Did the client have the ability to show thought and reason?  |  |  |
|  | Did the client show evidence of thought disorder during the assessment?  |  |  |
|  | Did the client’s short term and long-term memory appeared to be intact?  |  |  |

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| Therapeutic Support Required | Is counselling recommended / modality / recommendation to be entered here | Number of Sessions |   |
| Name of Recommended Practitioner  |  |

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| Please indicate if other Ben services are required as a follow up. | Life Coaching |  | SilverCloudSupported |  | SilverCloud Self-help |  |