**THERAPY CENTRE SERVICES**

**MID-WAY REVIEW FORM**

**CLIENT DETAILS**

|  |  |
| --- | --- |
| **Employer :** |  |
| **Client Reference :** |  |
| **Client Initials :** |  |
| **Number of sessions allocated :** |  |

**PRESENTING ISSUE**

|  |  |  |
| --- | --- | --- |
| 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 |

**RISK ASSESSMENT**

Please select if the client has previously attempted suicide, or has self-harmed

Y / N

Please select if the client has experienced suicidal ideations or feelings of wanting to self-harm

Y / N

**Current risk level :**

0 1 2 3 4 5

**WORKPLACE ASSESSMENT**

Is the client currently attending work?

Y / N

If no, how many days has the client been signed off in the last 30 days?

**MID-WAY REVIEW**

**Presenting issues :**

**Therapy Focus** (what have been the main focuses of the sessions together so far)

1.

2.

3.

**Signposting/Tools/Resources discussed:**

**Information regarding clinical recommendation for additional sessions:**

**Additional information:**