****

**Initial Session Summary**

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

|  |
| --- |
| **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