**Counselling Assessment Form**

|  |  |  |  |
| --- | --- | --- | --- |
| **Client ID:** |  | **Preferred pronoun:** |  |
| **Age:** |  | **Referral date:** |  |
| **Previously seen in this service:** |  | **Date first seen (this episode):** |  |
| **Referral route:** |  | **Educational provision and contact:** |  |

|  |
| --- |
| **Brief description of reason for referral:** |
|  |
| **Health or specific needs or preferences:** |
|  |
| **Self-Care: (e.g. sleep, eating, level of activity, personal care)** |
|  |
| **Social, leisure and hobbies:** |
|  |
| **Previous counselling:** |
|  |

**Timeline of significant events: (think about home, school, friendships, relationships, losses, changes etc)**

**Others around me: (think about family, friends, other adults, pets, teachers, positive and negative relationships, those alive and dead.)**

|  |
| --- |
|  |

**Risk Assessment:**

**High**

**Low**

|  |
| --- |
| **Risk** |
| Suicide |
| Self-harm |
| Harm to others |
| Harm from others |
| Social media/internet/ gaming |
| Substance use  |
| Eating |
| Bullying |
| Legal  |
| Other |

**What I feel I would like to achieve from counselling (how would things look if everything was OK?):**

|  |
| --- |
|  |

**Assessment Outcome:**

|  |  |  |
| --- | --- | --- |
| Assessment/one session only |  | **If not entering therapy, give brief reason below:** |
| Accepted for therapy |  |  |
| Accepted for trial period |  |
| Referred to other service |  |
| Unsuitable for therapy at this time |  |

**Comments/Notes:**

|  |
| --- |
|  |