MyOxfordCounsellor

Private practice at: 9 Park End Street & 7 Swinbourne Road in OXFORD

INITIAL CONSULTATION FORM

The purpose of this Initial Consultation Form is to gather information and to form a contract between you, the client, and myself Ventsi Vasev, the counsellor. This form is exclusively for our joint use and will not be shared with anyone else.

The services I will provide at the initial consultation session:

- ✓ Review the information in this Initial Consultation Form.
- ✓ Provide you with information and answer any questions on what counselling is.
- ✓ Outline your future therapeutic sessions.

The initial consultation session (*lasting about 40 min*) is to explore your therapy requirements and how I might be able to help you. It is also an opportunity for you to ask questions about the therapy. Also the initial consultation session will enable you to consider a range of different perspectives on your situation and understand how it is affecting you.
You will be offered some initial ideas and strategies for managing your particular psychological challenges.

One of three outcomes is possible following your initial consultation:

- ✓ We decide to start a number of therapeutic session;
- ✓ You may decide not to continue with the therapy sessions; or
- ✓ I may decide not to start counselling sessions with you.

Your personal information and responses in this Initial Consultation Form are fully confidential and will be held in accordance with the Data Protection Act 1998.

Initial Consultation Form

	Personal Details	
Surname:		
Forename(s):		Title:
Address:		
		Postcode:
Date of Birth:		
Marital Status:		Children/Ages:
Occupation:		
Telephone – Daytime:		Evening:
E-mail address:		
Doctor's (GP) Name and Address:		
		Postcode:
Emergency Contact:		Telephone:

	Case information
Have you ever had any therapy treatment before? If yes, where and when? Was it a beneficial for you?	
What is your major reason for being here today?	
How do you feel about your problem?	
What would you like to improve?	

What are your greatest concerns right now?		
For you, what would be the ideal solution?		
How well do you sleep?	Good Average Restless Poor	Average hours per night:
Do you suffer from:	Depression Tension Anxiety Stress	
How do the above affect you?		

	Medical History		
Are you on any medication? If so, what and what for?			
Relevant Medical History:			
Please state your Physical Wellbeing (0-100%)		**Please state your Mental Wellbeing (0-100%)**	

I _____ agree to the terms in this document and agree that all information in this document is correct.

Client Signature:	**Date:**
Counsellor Signature:	**Date:**