FENIKS. Counselling, Personal Development and Support Services Ltd.
St. Margaret's House, 151 London Road, EH7 6AE, Edinburgh
+44 7510 122 425, e-mail: info@feniks.org.uk
www.feniks.org.uk

THERAPY/COUNSELLING ASSESSMENT FORM

Client's Code…….

Assessment Date……..

Assessed By Therapist/Counsellor……..

Pathway
_Fast Service _Standard Service

PERSONAL INFORMATION
DOB: ..... Gender: .....

Nationality: _ Polish _ Other (please provide the nationality ……..)

GP (name / practice name and address) ……
……

SESSIONS
When is the client able to attend sessions? They are usually held at the same time, either weekly or fortnightly.

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Morning						
Afternoon						
Evening						

Please write down all the times the client can do (e.g. Monday morning: 8-10, afternoon 13-17, evening from 19.00)

Would the client like to be seen by a:
_ Female practitioner _ Male practitioner _ No preference _ A particular practitioner (please provide the name) ……..
Any special requirements / needs (e.g. wheelchair access, sign language, etc.)
……..

Would the client like to attend:
_ Individual sessions _ Relationship sessions

Medical/ psychiatric / therapy / counselling history
Any significant health problems or disability?
_ Yes (please provide details below) _No

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Current relevant medication (what medication, dose (if known), why they were prescribed and when)
_ Yes (please provide details below) _No
……
……

Alcohol / recreational drugs - past / present?
_ Yes (please provide details below) _No
……
……

Has the client ever physically harmed themselves in any way?
_ Yes (please provide details below) _No
……
……

Has the client ever considered taking their own life?
_ Yes (please provide details below) _No
……
……

Does the client have suicidal thoughts as of now?
_ Yes (please provide details below) _No
……
……

Has the client had therapy / counselling in the past?
_ Yes (please provide details below) _No
……
……

Is the client receiving any other form of therapy/seeing any other healthcare professional at present? (e.g. psychologist/psychiatrist/CPN)
_ Yes (please provide details below) _No

……

Social Situation
(occupation, potential financial and social issues, living arrangements, family & friends, environmental issues, emotional support, etc.)
……
……

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PRESENTING ISSUE(S)
Please tick all the boxes that apply. If there are issues not mentioned on the list, add them below. Please specify the main issue(s) the client sees as most urgent to address.

_Abuse/Trauma _Adaptation problems _Addiction: alcohol _Addiction: drugs _Addiction: gambling _Addiction: other (……) _Alcohol/substance misuse in family of origin _Anger and aggression _Anxiety _Bereavement/Loss _Bullying/Mobbing _Childhood Issues _Cognitive/Learning _Dealing with emotions _Depression _Domestic Violence _Eating disorder _Family Difficulties _Gender/sexuality _Interpersonal/Relationships _Isolation _ Living/Welfare _Mental Health diagnosis _Mood disorders _Panic attacks _Personality Disorders _Phobias _Psychosis _Self-esteem _Self-harming _Sexual _Stress _Studies _Suicidal thoughts/feelings _Suicidal attempts _Work _Other
……..

Main current issue(s):
……..

What would the client like from therapy / counselling?
……

INFORMATION FOR ALLOCATION

Client's Initials: …….. Code: ……..

Assessment Therapist / Counsellor's thoughts and feelings during and after the session:
……
……
……
……..

Appropriate for therapy / counselling?
_ Yes _No (please provide details below)
……

Type of therapist / counsellor required: _ Experienced / _ Not complete beginner / _ Any (including new students)

Referrals to other projects suggested?
_ Yes (please provide details below) _No

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Any other recommendations / suggestions?

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