

Email : martinkaren076@gmail.com

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Client History

This form is to be completed at Clients initial session.

Date of initial session:

Name:

E-mail:

Address:

City: Postcode:

Home phone (including code):Work phone (optional) :

Date of birth: \_\_\_/\_\_\_/\_\_\_\_\_\_ Age: Sex:

Marital status: No. of children:

Job Title/company

Doctor’s name:

Doctors Address:

Doctors Phone No. :

Have you had any previous counselling with a counselling practitioner?

No □ Yes □

Who?:

Reason:

**Medical History**

Have you been under a doctor’s care in the past year?

Yes □

No □

If yes, please give the reason:

Doctor’s name:

Hospital/GP Surgery Address:

Have you ever been treated for an emotional problem?

Yes □

No □

If yes, how long ago was your last treatment for an emotional problem?

Are you currently receiving treatment or counselling (including any medications you may have been prescribed)?

Yes □

No □

If yes, please give details of all treatment/counselling/medication below:

Have you had any prolonged illnesses?

Yes □

No □

If yes, please give details of all prolonged illnesses and treatment including prescribed medication below:

**Illness 1.**

When did illness start?:

How long did it last?:

Medication prescribed for said illness:

**Illness 2:**

When did illness start?:

How long did it last?:

Medication prescribed for said illness:

Have you ever been treated for any of the following:

Heart disease Yes □ No □

Diabetes Yes □ No □

Epilepsy Yes □ No □

If you have answered ‘Yes’ to any of the above, please list any and all medications you have prescribed for these conditions and their frequencies of use:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Counselling Information**

Reason you are coming for Counselling:

Have you engaged in any previous efforts to solve the issues?

Yes □ No □

Results:

Are you currently undergoing medical or psychological treatment for the above problem?

Yes □ No □

Where?:

Doctor’s name:

Do have any questions about Counselling?

Yes □ No □

If yes, please list here:

What is your goal for therapy ?:

Agreed form of contact in between sessions :

Email telephone text ( underline those appropriate to you )

**Client Consulting Agreement**

I agree that the answers I have given above are correct and accurate to the best of my ability and knowledge. Should it be found that I have knowingly mis-led the aforementioned therapist, Counselling treatment will be terminated forthwith with no personal or professional ramifications falling to the aforementioned therapist. I know my heartfelt commitment is an important first step in my work here, and my signature below underscores that commitment.

I also agree:

* To attend and be on time for appointments
* I understand that my appointment duration is 50 minutes. For EMDR 90 minutes.
* To meet my financial obligations in advance of therapy sessions.
* To participate wholeheartedly in the work I am undertaking.
* Cancelling my appointment with less than 24hrs notice will result in my being charged for the missed appointment.
* I understand that Karen Martin operates under the ethical guidelines of the National Counselling Society and BACP. Within these guidelines are also that Professional Indemnity Insurance is held. All certifications of proof are available on request. If there should be a need to complain, the accreditation body complaints procedure is to be followed.

In accordance with the current GDPR Data Protection Laws, I consent to the following:

* The therapist, Karen Martin can store and use my personal details to contact me for clinical reasons only if necessary.
* I understand that my details will not be shared by Karen Martin in any way that I do not give my consent to.
* I also agree and understand that in accordance with the therapists’ professional body, clinical notes can/will be held by Karen Martin for up to 7 years after the end of our treatment under strict confidentiality guidelines. I am legally allowed to see any clinical notes kept of me.

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapists Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_