**NEW ONLINE CLIENT INFORMATION** *(Please complete as much information as you feel comfortable with. This information is useful for our therapeutic work together as well as ensuring your safety. All information is kept confidential and secure, and will be deleted when we complete our time together).*

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mobile/Other phone number(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary email address (for administrative contact)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Protonmail email address (if already set up, for Therapy Emails) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email used on Microsoft teams, or Zoom (if already set up; for webcam sessions)

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

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Date of birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship Status** (check one):

Single \_\_\_\_ Married/Committed Relationship \_\_\_\_ Widowed \_\_\_\_ Divorced/Separated \_\_\_\_

How long in current married/committed relationship? \_\_\_\_\_\_\_\_\_\_\_­­­­­­­­\_\_

Do you have children? \_\_\_\_ If yes, ages and genders \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History**

Local GP (name and surgery) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ­­­­­­­­­­­­­­

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Current problems, symptoms or concerns \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Current prescription medications (name & dosage) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Date and nature of previous significant physical problems \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Currently in counselling or psychotherapy? Yes \_\_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_\_

Previous counselling or psychotherapy? Yes \_\_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_\_

For how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous psychiatric hospitalisation (where/when) Yes \_\_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_\_

Length of stay \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have any family members ever had mental health problems or been diagnosed with a mental disorder? \_\_\_\_\_Yes \_\_\_\_\_No

If yes, who is it and what is the problem? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Contact in case of medical or psychological emergency**: (Note:*This person would only be contacted with your consent, or during life threatening circumstances.)*

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Levels of Distress:** *(Your answers to these questions will help me to understand your current levels of distress, though we will also talk in more detail about the difficulties you’ve been experiencing during our sessions).*
 ***(tick or ‘X’ the appropriate boxes)***

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ***Over the last week..........*** | ***Not at All*** | ***Only occasionally*** | ***Sometimes*** | ***Often*** | ***Most or all of the time*** |
| *1. I have felt tense, anxious, or nervous.* |  |  |  |  |  |
| *2. I have felt I have someone to turn to for support when needed.* |  |  |  |  |  |
| *3. I have felt able to cope when things go wrong.* |  |  |  |  |  |
| *4. Talking to people has felt too much for me.* |  |  |  |  |  |
| *5. I have felt panic or terror.* |  |  |  |  |  |
| *6. I have made plans to end my life.* |  |  |  |  |  |
| *7. I have had difficulty getting to sleep or staying asleep.* |  |  |  |  |  |
| *8. I have felt despairing or hopeless.* |  |  |  |  |  |
| *9. I have felt unhappy.* |  |  |  |  |  |
| *10. Unwanted images or memories have been distressing me.* |  |  |  |  |  |