**CARRS LANE COUNSELLING CENTRE LTD**

**Client Pre-Therapy Questionnaire**

**Client Name:…………………………………………… Client Reference Number:………………….**

**Date: …………………………………………………….. Date of Birth:……………………………………..**

**Do you understand how counselling might help you?**

**Who has suggested you attend. e.g. Social worker, carer, solicitor, G.P, psychiatrist, CPN or other mental health worker?**

**Please give GP name and practice address:**

**Have you had past or current psychiatric involvement or previous or current therapy?**

**Do you have any other health concerns or disabilities?**

**Are you taking prescribed medication?**

**Do you have concerns arounds:**

* **Managing anger**
* **Violence to others**
* **Harm to self (including suicidal thoughts)**
* **Sleeping or eating disorders**
* **Alcohol or drug misuse**

**Do you have support of family or friends or do you live alone?**

**Signed by Client: …………………………………… Signed by Counsellor: …………………………**