Required information:

**Name:** Click or tap here to enter text. **Date of Birth:** Click or tap here to enter text.
**Address:** Click or tap here to enter text.

**Phone:** Click or tap here to enter text. **Email:** Click or tap here to enter text.

**Can we leave / send a detailed message?**
If yes, please check box: Email: [ ]  Phone: [ ]  Text: [ ]  Voicemail: [ ]
Any notes: Click or tap here to enter text.

Your mental health:

**In your own words, what are your current issues:** Click or tap here to enter text.

**When did the problem start:** Click or tap here to enter text.

**Have you been given any diagnoses:** Click or tap here to enter text.

**Previous therapy sessions:** Click or tap here to enter text.

**Previous mental health issues:** Click or tap here to enter text.

**Family history of mental health issues (if known):** Click or tap here to enter text.

Your health:

**Do you have any physical health issues:** Click or tap here to enter text.
**Do you take any medication:** Click or tap here to enter text.

GP Surgery:

**Address:** Click or tap here to enter text.
**Named GP (if known):** Click or tap here to enter text.
**Telephone:** Click or tap here to enter text. **Email (if known):** Click or tap here to enter text.

Your life now:

**Is there anything in your life which could be contributing to your difficulties? E.g. job, finances, family:** Click or tap here to enter text.
**Do you have a partner / children?** Click or tap here to enter text.
**Do you currently work / study?** Click or tap here to enter text.
**Who do you live with?** Click or tap here to enter text.

Barriers to therapy:

**Do you have difficulties with reading or writing? If yes, is there anything we can do to make things easier for you?** Click or tap here to enter text.

**Do you have cultural issues that we need to be aware of? If yes, is there anything we can do to make things easier for you?** Click or tap here to enter text.

**Do you have any other issues that we need to be aware of? If yes, is there anything we can do to make things easier for you?** Click or tap here to enter text.

Risk assessment:

Have you ever had thoughts that you would be better off dead or of hurting yourself in some way?

Yes [ ]  No [ ]

Have you had thoughts that you would be better off dead or of hurting yourself in some way over the past two weeks?

Yes [ ]  No [ ]

If yes, over the past two weeks, how often have you experienced thoughts that you would be better off dead or of hurting yourself in some way?

Nearly every day [ ]  More than half the days [ ]  Several days [ ]  Not at all

Have you attempted to harm yourself or end your life before?

Yes [ ]  No [ ]

If yes, when was the last time you attempted to harm yourself or end your life?

Click or tap here to enter text.

Do you have thoughts to hurt other people?

Yes [ ]  No [ ]

***If you require support with these thoughts, please contact your GP, call the Samaritans on 116 123, text ‘shout’ to 85258, call 111, go to A&E or if you cannot get there safely to call 999.***

Emergency contact / legal guardian details:

**Name:** Click or tap here to enter text. **Date of Birth:** Click or tap here to enter text.
**Address:** Click or tap here to enter text. **Relationship to you:** Click or tap here to enter text.

**Phone:** Click or tap here to enter text. **Email:** Click or tap here to enter text.

**Can we leave / send a detailed message?**
If yes, please check box: Email: [ ]  Phone: [ ]  Text: [ ]  Voicemail: [ ]
Any notes: Click or tap here to enter text.

Optional demographic information:

**Marital status:** Click or tap here to enter text. **Gender:** Click or tap here to enter text.
**Ethnic background:** Click or tap here to enter text. **Faith:** Click or tap here to enter text.
**Sexual orientation:** Click or tap here to enter text.

Improving our service:

**How did you find us? (E.g. Specific website)**  Click or tap here to enter text.