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.