Michelle Jackson

Counsellor

2 Park Gate, Park Road, Ipswich, IP1 3TU

**Counselling Contract**

The purpose of this document is to gather information and to establish a contract between you, the client and myself Michelle Jackson, the counsellor. This form is solely for our use and will not be shared with anyone else.

**The services I will provide at the initial consultation session**

1. Review the information in this form.
2. Provide you with information and answer any questions that you have.
3. Outline your future therapeutic sessions.

The initial consultation session is to explore your therapy requirements and how I may be able to help you. It is also an opportunity for you to ask questions about the therapy. The initial consultation session will also enable you to consider a range of different perspectives on your situation and understand how it is affecting you.

You will be offered some initial ideas and strategies for managing your particular psychological challenges.

We will agree to follow one of three outcomes following your initial consultation:

1. We decide to start a number of therapeutic sessions;
2. You may decide not to continue with the therapy sessions; or
3. I may decide not to start counselling sessions with you.

Your personal information and responses in this contract are fully confidential and will be held in accordance with the Data Protection Act 1998.

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| --- | --- | --- |
| Personal Details |  |  |
| Surname: |  |  |
| Forename(s): |  | Title: |
| Address: |  | Postcode: |
| Date of Birth: |  |  |
| Marital Status: |  | Children/Ages: |
| Occupation: |  |  |
| Telephone – Daytime: |  |  |
| Email address: |  |  |
| Doctor’s (GP) Name and Address: |  | Postcode: |
| Emergency Contact: |  |  |
|  |  |  |

|  |  |
| --- | --- |
| Case Information |  |
| Have you ever had any therapy before? If yes, where and when? Was it beneficial for you? |  |
| What is your major reason for being here today? |  |
| How do you feel about your problem? |  |
| What would you like to improve? |  |
| What are your greatest concerns right now? |  |
| What would be the ideal solution for you? |  |
| How well do you sleep? | Well Average Restless PoorAverage hours per night |
| Do you suffer from: | Depression Anxiety Tension Stress |
| How do the above affect you? |  |
|  |  |

|  |  |
| --- | --- |
| Medical History |  |
| Are you currently on any medication? |  |
| If yes, please state what you are taking and why |  |
| Relevant medical history |  |
| Please state your physical wellbeing (1 to 10) |  |
| Please state your mental wellbeing (1 to 10) |  |
|  |  |

I agree to the terms in this document and agree that all the information provided within is correct.

**Client Signature: Date:**

**Counsellor Signature: Date:**