

**REGISTRATION FOR COUNSELLING**

**www.cfl.uk.com**



For clients wishing to attend relationship counselling, **please complete a form each** and include the name of your partner below:

|  |  |
| --- | --- |
| **Full Name and preferred title (Mr, Mrs, etc.):** |  |
| **Address including Postcode:** | Click or tap here to enter text. |
| **Date of Birth:** | Click or tap here to enter text. |
| **Contact Telephone (day & eve):** | Click or tap here to enter text. |
| **Email:** | Click or tap here to enter text. |
| **Preferred Method of Contact:**(email, phone etc) | Click or tap here to enter text. |
| **Partner’s name:** (For relationship counselling only)  | Click or tap here to enter text. |
| **Name of Emergency Contact:****Relationship to Emergency Contact:** | Click or tap here to enter text. Click or tap here to enter text. |
| **Emergency Contact Telephone No:** | Click or tap here to enter text. |

**Do you wish to see your therapist face-to-face, online (via Zoom) or by telephone?**

Face to Face Counselling [ ]  Online Counselling [ ]  Telephone Counselling [ ]  I am flexible [ ]

**Counselling Fees**

Individual Initial Assessment: £65 Online and £75 Face to Face

Individual Standard Session: £55 Online and £65 Face to Face

Relationship Initial Assessment: £80 Online and £90 Face to Face

Relationship Standard Session £80 Online and £90 Face to Face

If these costs would prevent you from accessing therapy and you wish to find out more about our Financial Assistance Programme (FAP) please tick here [ ]  (Please indicate the maximum fee you can afford £ \_\_\_ )

Our preferred method of payment is by direct debit via GoCardless. A GoCardless direct debit mandate form will be sent to you once an assessment appointment has been arranged.

**Availability for Counselling** (please put a X to the days and times that you would be able to attend regularly. Evening sessions from 6pm are Zoom ONLY sessions )

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | 9am | 10am | 11am | 12pm | 1pm | 2pm | 3pm | 4pm | 5pm | 6pm | 7pm | 8pm |
| MON |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| TUE |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| WED |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| THU |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| FRI |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

|  |  |
| --- | --- |
| **Name of GP** | Click or tap here to enter text. |
| **GP Practice Address** | Click or tap here to enter text. |
| **GP Telephone Number** | Click or tap here to enter text. |
| **Current Medical Health** **(please describe any illnesses or health conditions requiring treatment)** | Click or tap here to enter text. |
| **Current Prescribed Medications** | Click or tap here to enter text. |
| **Mental Health (please provide any prior or ongoing mental health conditions or involvement with Mental Health Services)** | Click or tap here to enter text.  |
| **Previous Counselling Attended****(please give approximate dates and duration of therapy)** | Click or tap here to enter text.  |
| **How did you hear about Counsel For Life?** | Click or tap here to enter text. |
| **If you would like to provide further information, please do so here:** |
| Click or tap here to enter text. |

 Please indicate which issues may be affecting you. Please put an X in the relevant boxes, use as many as needed.

|  |  |  |  |
| --- | --- | --- | --- |
|  | **X****if relevant** |  | **X** **if relevant** |
| **Anger** |[ ]  Separation Issues |[ ]
| **Anxiety** |[ ]  Spiritual Crisis |[ ]
| **Bereavement** |[ ]  Stress |[ ]
| **Chronic Disability** |[ ]  Suicidal Thoughts and/or Feelings |[ ]
| **Chronic Illness** |[ ]  ABUSE: |  |
| **Depression** |[ ]  Emotional |[ ]
| **Domestic Abuse/Violence** |[ ]  Neglect |[ ]
| **Emotional Breakdown** |[ ]  Physical |[ ]
| **Family Dynamics** |[ ]  Sexual |[ ]
| **Financial Worries** |[ ]  EATING DISORDERS: |  |
| **Identity Issues** |[ ]  Anorexia |[ ]
| **Life Changes** |[ ]  Binge Eating |[ ]
| **Loss** |[ ]  Bulimia |[ ]
| **Low Self-Esteem** |[ ]  ADDICTIONS: |  |
| **Phobias** |[ ]  Alcohol |[ ]
| **Relationship Difficulties/Breakdown** |[ ]  Drugs |[ ]
| **Self-Harm** |[ ]  Gambling |[ ]
| **Self-Injury** |[ ]  Pornography |[ ]
| **OTHER please specify:**  |[ ]   |  |
| Click or tap here to enter text. |

|  |  |  |  |
| --- | --- | --- | --- |
| **Signed:** | Click or tap here to enter text. | **Date:** | Click or tap here to enter text. |
| Drop image file here |  |  |  |

ALL INFORMATION WILL BE HELD IN STRICT CONFIDENCE

PLEASE EMAIL COMPLETED FORM BACK TO pwtcfl@aol.com or post to:

Counsel for Life, 10 Crescent, London, E18 1JB

**BOTH PARTNERS NEED TO COMPLETE A FORM FOR RELATIONSHIP COUNSELLING**