|  |
| --- |
| **YOUR DETAILS** |
| **Title:** **Full Name:****Date of Birth:****Contact Number:****Email:** | **Diagnosis:****Current Prescribed Drugs:**MALE / FEMALETherapist preference? Any active substance/alcohol abuse? YES / NOAny major risks at time of assessment? YES / NO |
| **Date of Birth:****Gender:****Marital Status:****Religion:****Sexual orientation:** | **Ethnicity:** African⬜Asian or Asian-British ⬜Black or Black- British ⬜Caribbean ⬜Mixed Black ⬜Other Ethnicity ⬜**Specific Ethnicity:** | **NEXT OF KIN** |
| **Name:****Telephone No:** |
| **THERAPY SESSIONS**  |
| **Have you had therapy before?**Yes ⬜ No ⬜**Reasons for wanting Therapy?****What issues would you like to work on with the Therapist?****What days and times would you be available for sessions?** |
| **MENTAL HEALTH HISTORY** |
| **Please confirm any mental health diagnosis?**YES ⬜ NO ⬜ **Any other information you want to share?** |
| **CONSENT** |
| Please can you confirm that you are happy for your information to be viewed only by RESET MH and the therapist. Pease sign (e-signature accepted) the form confirming this and that all the details given are accurate. **SIGNATURE:** |