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| **YOUR DETAILS** | | |
| **Title:**    **Full Name:**    **Date of Birth:**  **Contact Number:**  **Email:** | | **Diagnosis:**  **Current Prescribed Drugs:**  MALE / FEMALE  Therapist preference?  Any active substance/alcohol abuse?  YES / NO  Any 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:** | |