

**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 |  |  |  |  |  |  |  |  |  |  |  |  |

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| --- | --- |
| **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](mailto:pwtcfl@aol.com) or post to:

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

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