Chris Jones Therapy – Initial Assessment

Name: D.O.B: Gender:

Address:

Telephone:

Email:

Doctor’s Name:

Address:

Telephone:

Mental Health Diagnosis or Medication

Previous Counselling/Therapy

Marital/Relationship Status:

Occupation/Current Work Life:

Feelings About Self:

Suicide Ideation/Attempts:

Bullet Points of Presenting Problem/s:

Any Other Comments: