



Referral Details

Referral From	Tick	Contact Person	Name of Organisation
Private Referral			
Institutional Referral			
Court Referral			
Other Services involved			

Reason for Referral

Presenting Issue		
Secondary issues		

Contact Details for Client and Emergence Person Details

Name	Mobile	Email
Client:		
Emergency:		



Client Details

Clients age and date of birth	Age	DOB
Partner/Spouse Name	First Name	Year(s) together
Relationship with partner/Spouse		

Any Previous experience of therapy (Style of therapy)	Issues addressed	Length of therapy
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Medical Details

Symptoms/Diagnosis	Type	Severity
Medication		

Vulnerable Adult Details

Parents/Guardians Name	First Name	Surname
Mother's Name		
Father's Name		
Guardian's Name		
Other – relationship to Adult		



Family Details

Parents/Guardians relationship status	Together/Single parenting	Separated/Co-Parenting
Grandparents/Grandguardians relationship status	Together/Single parenting	Separated/Co-Parenting
Siblings/ Step-Siblings Name	Age	Gender
Foster Siblings	Age	Gender

Relationship to Siblings/Foster Siblings	Name	Positive/Negative/Neutral



Extended Family Details

Significant People	First Name	Positive/Negative/Neutral
Significant Pets	Name	Positive/Negative/Neutral

Friends personal/work

Friends Name	Personal	Work

Work/College Attendance Details

Attendance	Able to attend	Difficulties attending
Issues around attendance	Historical	Recent



Behavioural/Communication Details

Behaviour and Communication	Able to express your needs	Difficulties with expressing your needs
Issues around Behaviour and Communication For example : nightmares, sleepwalking, bed wetting, sudden change in eating patterns, food refusal, violence towards self, violence towards others, self-harm, suicidal thoughts, addiction,	Historical	Recent

Client aims for therapy/Changes you would like

Aims for Client		
Changes you would like to see		



Trauma History for family

Did you or your child experience or witness any of the following events, as a child or adult?	Were you bothered by this at the time?	Are you bothered by this now?
Natural Disaster		
<input type="checkbox"/> Flood <input type="checkbox"/> Hurricane/tornado <input type="checkbox"/> Fire <input type="checkbox"/> Earthquake	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
Accidents		
<input type="checkbox"/> Medical/surgical error <input type="checkbox"/> Motor vehicle accident <input type="checkbox"/> Plane crash <input type="checkbox"/> Drowning <input type="checkbox"/> Explosion <input type="checkbox"/> Chemical/gas leak <input type="checkbox"/> Building collapse	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
Illness		
<input type="checkbox"/> Unexpected death of a loved one <input type="checkbox"/> Serious medical illness <input type="checkbox"/> Serious mental illness	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
Neglect/Humiliation		
<input type="checkbox"/> Being denied food or water <input type="checkbox"/> Left alone for long periods <input type="checkbox"/> Put in dangerous situations <input type="checkbox"/> Verbally humiliated or ignored <input type="checkbox"/> Forced to perform humiliating actions <input type="checkbox"/> Insulted/treated as worthless <input type="checkbox"/> Teased/bullied	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
Control		
<input type="checkbox"/> Being locked in a room/closet <input type="checkbox"/> Controlled use of phone <input type="checkbox"/> Being stalked <input type="checkbox"/> Controlled contact with others	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No



<input type="checkbox"/> Controlled possessions <input type="checkbox"/> Forced to take drugs or alcohol	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
Did you or your child experience or witness any of the following events, as a child or adult?	Were you bothered by this at the time?	Are you bothered by this now?

Physical Punishment		
<input type="checkbox"/> Being hit, kicked, thrown, dragged, or tied up <input type="checkbox"/> Being bruised, burned, cut or given broken bones <input type="checkbox"/> Witnessed violence on other family members	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
Unwanted sexual contact		
<input type="checkbox"/> Forced intercourse (oral, anal, or vaginal) <input type="checkbox"/> Forced masturbation <input type="checkbox"/> Forced to watch pornography <input type="checkbox"/> Being fondled against your will <input type="checkbox"/> Forced to perform sexual acts in front of others <input type="checkbox"/> Being filmed or videotaped <input type="checkbox"/> Being prostituted	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
Assault and robbery		
<input type="checkbox"/> Victim of robbery <input type="checkbox"/> Assaulted with a weapon <input type="checkbox"/> Threatened to be killed <input type="checkbox"/> Beaten up <input type="checkbox"/> Kidnapped/held hostage <input type="checkbox"/> Witnessed a murder/assault	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
Neglect/Humiliation		
<input type="checkbox"/> Being denied food or water <input type="checkbox"/> Left alone for long periods <input type="checkbox"/> Put in dangerous situations <input type="checkbox"/> Verbally humiliated or ignored <input type="checkbox"/> Forced to perform humiliating actions <input type="checkbox"/> Insulted/treated as worthless <input type="checkbox"/> Teased bullied	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No



Stigma and prejudice		
<input type="checkbox"/> Race <input type="checkbox"/> Gender <input type="checkbox"/> Religion <input type="checkbox"/> Ethnic or national identity <input type="checkbox"/> Income <input type="checkbox"/> Sexual orientation	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
War		
<input type="checkbox"/> Served in a combat zone <input type="checkbox"/> Treated the wounded in combat <input type="checkbox"/> Was fired upon in combat <input type="checkbox"/> Close-hand combat <input type="checkbox"/> Prisoner of war <input type="checkbox"/> Friendly fire	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
Other events		
<input type="checkbox"/> Miscarriage/stillbirth <input type="checkbox"/> Abortion <input type="checkbox"/> Adoption <input type="checkbox"/> Foster or residential care <input type="checkbox"/> Removed from home by the state <input type="checkbox"/> Homeless/lived on the streets <input type="checkbox"/> Subject of a lawsuit <input type="checkbox"/> Being falsely accused <input type="checkbox"/> Arrest/imprisonment <input type="checkbox"/> Hospitalised against will <input type="checkbox"/> Being embezzled/blackmailed <input type="checkbox"/> Spouse/partner had an affair <input type="checkbox"/> Unexpected demotion or loss of job <input type="checkbox"/> Identity theft	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No