

**ST PAUL’S CENTRE, 102A CHURCH STREET, ENFIELD, MIDDLESEX, EN2 6AR**

**Tel: 020 8367 2333 Email:** [**info@enfieldcounselling.co.uk**](mailto:info@enfieldcounselling.co.uk) **Web: www.enfieldcounselling.co.uk**

APPLICATION FORM FOR COUNSELLING – CONFIDENTIAL

Date sent to client ...................... Date received at ECS ...............................

If known, please indicate the type of counselling applied for

**Individual.................................Couple ……….………………..........................................................................**

**Name(s) Mr/Mrs/Ms/Miss……………………………………..….………………………...................................................**

**CAPITALS PLEASE**

**Address:** …………………………………………………………………………………….................................................................

…………………………………………………………………………………………………...................................................................

### **Tel. numbers**: Home…………………….........................…............ Mob.................................................................

### **Email:** .............................................................................................................................................................

**Is it acceptable to you for us to contact you by telephone?** **Yes / No**

**How did you find out about this service?**

**...............................................................................................................................................................**

**Although your initial assessment interview will be held during the day, we can usually arrange on-going counselling at mutually convenient times.**

**On which weekdays are you usually available for an assessment appointment?**

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**Could you let us know your reasons for seeking counselling:**

**Have you had any counselling/therapy before?** (If so, please give some details here i.e. when, for how long, with whom)

# **Is there anything else you would like us to know?**

**It is useful for us to have some more personal details before your first appointment. Please feel free to fill in as much or as little as you wish.**

I am single/ married/ co-habiting/ separated/ divorced/ widow/widower and have been for..................months/years

Date of Birth…………..............................................

My occupation (paid or unpaid) Full/part time

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Family members** | **First Name** | **Age** | **If deceased, age when died** | **Your age at the time** | **Living with you now?** |
| **Father** |  |  |  |  |  |
| **Mother** |  |  |  |  |  |
| **Partner/spouse** |  |  |  |  |  |
| **Siblings(s)** |  |  |  |  |  |
| **Children** |  |  |  |  |  |

Which ethnic group do you place yourself in? …………………………………………………

**Medical details**

If you start counselling here, your counsellor will normally write a courtesy letter to your GP letting them know this, and asking if there is any reason why they think you should not do so. The counsellor would not communicate further with your GP without your knowledge, and we would like permission for them to write this initial letter. If you do not wish to give consent, it can be discussed during your first appointment.

Name and Address of GP ……………………………………………………………….......

……………………………………………………………….......

I give ECS permission to make contact with my GP **Yes/No**

**...................................................................................................................................................................**

Are you at present receiving psychiatric treatment and/or medication? **Yes/No**

Please give details here:

If you are receiving psychiatric treatment, we **must have** your permission to contact your psychiatrist to confirm it is appropriate for us to offer you counselling. We cannot go further with this application without your permission. Please sign below.

Name of psychiatrist………………………………………………………....................................................................……………

Address …………………………………………….....................................................................………………………….….............

I give ECS permission to make contact with my psychiatrist **Yes/No**

## I ENCLOSE £45.00 (non-refundable) assessment fee or have made a payment by BACS

(Cheques made payable to Enfield Counselling Service; BACS to Enfield Counselling Service, CAF Bank, Account No: 00009093, Sort Code: 40 52 40)

Signed…………………………………………….. Date………………….....

Please return to: Enfield Counselling Service, St Paul’s Centre, 102A Church Street, Enfield, EN2 6AR