

Client Information Form

Section 1: This section is for chrysalis centre admin and not to be completed by the referrer.

Referral Date:		Referral Route: (online / email / phone)	
Assessment Type:		Assessment Date:	

Sections 1 & 7 are to be completed by Chrysalis Centre admin
Referrer / client to complete sections 2 – 5 below. Section 6 is optional

Section 2: Client & Referrer Details	
Details of person being referred:	How did you hear about CCC / Referrer details:
Surname:	Name:
First Name:	Job Title:
Date of Birth: Age:	Organisation:
Address (please include postcode):	Contact No:
	Details of GP (unless already given above)
	Named GP:
<i>Can we send post to this address?</i>	Surgery Name:
Mobile No:	Please BRIEFLY give the MAIN reason for referral (e.g. domestic abuse)
Landline number (if no mobile):	
<i>Can we phone you on above number/s?</i>	
<i>Can we send texts to above number?</i>	
<i>Can we leave voicemails on above number/s?</i>	

Section 3: Email Contact & Permissions	
Email Address of person being referred:	
Can we contact you by email?	Can we send updates about the Chrysalis Centre by email?
Can we send occasional surveys or opinion polls about the Chrysalis Centre by email?	

Section 4: Health Information: Do you have any of the following illnesses or conditions (Tick all that apply)		
Mental Health Problems <input type="checkbox"/>	Learning Difficulties <input type="checkbox"/>	Epilepsy <input type="checkbox"/>
Physical Health Problems <input type="checkbox"/>	Asthma <input type="checkbox"/>	Seizures <input type="checkbox"/>
Hearing / Visual Impairments <input type="checkbox"/>	Any other serious / life threatening conditions <input type="checkbox"/>	
If you have ticked any of the above, please provide any relevant information below including medication, adjustments:		
Please provide below details of someone we can contact on your behalf in an emergency:		
Full Name	Contact Number	Relationship to you

Client Information Form

Section 5: Service Information

Are you involved with any other services, e.g., Social Services, Home Treatment Team, Jobcentre, Safe2Speak?

Can we share information with other professionals about your engagement with Chrysalis Centre? Yes No

Please indicate below if you have ever been referred to the MARAC (Multi-Agency Risk Assessment Conference)

Referred to MARAC in the last 6 months Referred to MARAC more than 6 months ago Date of MARAC if known

Please indicate below if you are involved in a pending or current court case and the reason why (e.g., child custody)

Pending Current Reason:

Please indicate what you would like to gain by engaging with the Chrysalis Centre. Tick all that apply

Reduction in anxiety	<input type="checkbox"/>	Support for addiction	<input type="checkbox"/>	Improve self-esteem	<input type="checkbox"/>
Stress Management	<input type="checkbox"/>	Support with anger	<input type="checkbox"/>	Increased confidence	<input type="checkbox"/>
Support for depression	<input type="checkbox"/>	Support for trauma	<input type="checkbox"/>	Assertive Skills	<input type="checkbox"/>
Domestic abuse support	<input type="checkbox"/>	Reduce suicidal thoughts	<input type="checkbox"/>	Social inclusion	<input type="checkbox"/>
Bereavement support	<input type="checkbox"/>	Coping skills	<input type="checkbox"/>	Improved relationships	<input type="checkbox"/>
Work / volunteering or FE	<input type="checkbox"/>	Improved Wellbeing	<input type="checkbox"/>	Other (use box below)	<input type="checkbox"/>

If you ticked other, please explain:

Which services would you like to access at the Chrysalis Centre?

Counselling requires that you commit to attending for a one-hour session at the same time on the same day each week for a minimum of 8 weeks. Appointments are available in person, over the phone or by zoom. Please indicate your preference/s and your availability so that we can allocate you to a suitable counsellor. Tick all that apply

In person Phone Zoom Availability:

Section 6: OPTIONAL. Equalities information is only ever reported ANONYMOUSLY

Your Ethnicity		Your marital status	
Are you Disabled?		Culture, Belief, Religion	
Your sexual orientation		Gender Identity	

Have you ever identified as transgender?

Section 7: This section is for chrysalis centre admin and not to be completed by the referrer.

By signing below I understand and agree that the information on this form is correct to the best of my knowledge.

Client Signature: _____ Date: _____

Team Member Signature: _____ Date: _____

Client Wellbeing & Risk Assessment

Please choose one number between 1 and 5 for each statement that you feel best describes your experience over the last 2 weeks.

	STATEMENTS	None of the time	Rarely	Some of the time	Often	All of the time
1	I've been feeling nervous, anxious or on edge	1	2	3	4	5
2	I've not been able to stop or control worrying	1	2	3	4	5
3	I've felt little interest or pleasure in doing things	1	2	3	4	5
4	I've been feeling down, depressed or hopeless	1	2	3	4	5
5	I've displayed violent / aggressive behaviour towards someone	1	2	3	4	5
6	I have hurt myself physically or taken dangerous risks with my health	1	2	3	4	5
7	I've been feeling good about myself	1	2	3	4	5
8	I've been feeling confident	1	2	3	4	5
9	I've been feeling terribly alone and isolated	1	2	3	4	5
10	I've been able to make up my own mind about things	1	2	3	4	5
11	Talking to people has felt too much for me	1	2	3	4	5
12	I've felt I've someone to turn to for support when needed	1	2	3	4	5
13	I have felt distressed by unwanted images or memories	1	2	3	4	5
14	I have been happy with the things I have done	1	2	3	4	5
15	I've been able to set goals and work towards achieving them	1	2	3	4	5
16	I've been dealing with my problems well	1	2	3	4	5
17	I've made plans to end my life	1	2	3	4	5
18	I've been feeling useful	1	2	3	4	5
19	I've been using drugs and/or alcohol as a way of coping	1	2	3	4	5
20	I've felt afraid, humiliated or shamed by another person	1	2	3	4	5