MAKE SURE ALL INFORMATION IS COMPLETED CORRECTLY

INITIAL CONTACT FORM

Wellbeing Worker:		Date:	

CLIENT NAME AND TITLE			
Address:		Tel No.	Gender:
		Message OK yes / no	Re-assessment
		Origin. walk in / phone /email/ letter/website	
Postcode		Email Address:	
Date of Birth	Actual Age	Referral Type	
GP Name		Surgery	

Ethnic Background	Child Under 5		

Working client Yes / No

Age 19 -25 Yes / No

1 Why have you contacted the service?

2 Have you been to your GP about this? Yes / No When ....

3 What Diagnosis have you been given? ....

Have you been prescribed medication? Yes / No

4 Are you involved with any other agencies? (please Tick)

Hewat / CMHT
Avalon
Probation
Adult services
Homeless
Other (please indicate)

5 Have you accessed our service before? Yes / No When ……………………………….

6 Do you have any physical health problems which we need to know about?

7 Do you have any History of Violence or aggression? Yes / No

Details….

8 Do you have any Criminal Convictions?

Details…….

9 Do you identify yourself as having a learning disability?

Details………..

You will receive a phone call back from one of our Practitioners in the next 7 days

Are there any times which are best for you? …………………………………………………..