**Pre-Therapy Assessment Form**

(Under 18’s)

The purpose of this form is to help me get to know a bit about you, your needs, and how you feel therapy might help you. Where possible, it is best if the young person seeking therapy completes this form themselves. If that's not possible, I suggest the young person completes the form with a trusted adult who can provide assistance where needed.

**Your Details:**

First Name:                 Family Name:               

How old are you?      

What country do you live in?                          

Can you read, write and speak in English? (check one) YES NO

Do you live at home with your parents? (check one) YES NO

Do you live with someone besides your parents? (check one) YES NO

If yes, who do you live with?

What is your home address?

                         

Do you have an email address? (check one) YES NO

If you have an email address, please write it here:           

If you don’t have an email address, can you provide a parent’s/guardian’s email address that you could access, if needed? (please write it here):

Are you currently or have you recently received support from any of the following for your mental health/wellbeing?

|  |  |  |
| --- | --- | --- |
| GP/Paediatrician | A Psychiatrist | Social Services |
| Children & Adolescent Mental Health Services (CAHMS) | A Psychologist | Emergency Care/ Hospital Admission |
| School/Guidance Counsellor | An Inpatient Facility | Any other mental health service/charity |

**How and when would you like to meet?**

Would you most like for us to speak together by (check one)…..

Email Instant Messenger Audio Call (Zoom) Video Call (Zoom)

What day would you like to meet? (check one)

Monday Tuesday Wednesday

Would you like to meet (check one)……..

In the morning? In the afternoon? In the evening?

**What Can I Help You With?**

**Can you tell me a bit about what’s been troubling you?**

|  |
| --- |
|  |

**Can you tell me how you feel therapy might help you?**

|  |
| --- |
|  |

Please check any of the things below that you’ve been struggling with:

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
| Feeling sad | Problems at school | Disliking my body | Having no appetite/ not eating much |
| Hurting myself when I am upset | Feeling scared often | Feeling anxious/nervous | Low self-esteem |
| Having no friends/ feeling isolated | Having nightmares or night terrors | Feeling very angry | Overeating/ binging or purging |
| Violent/Intrusive thoughts | Not wanting to be around people | Not wanting to talk to people | Feeling worthless or useless |
| Feeling stressed or overwhelmed | Trouble sleeping/ getting to sleep | Feeling unable to cope with things | Feeling hopeless about my life |

Thanks for completing this form. ☺

You can send your finished form to me at [cloie@diversemindstherapy.org](mailto:cloie@diversemindstherapy.org). It’s a good idea to **password protect** this document to keep your information private. This will ensure that I am the only one who reads your answers. Please password protect your completed form with the password: **DMiTherapy23**

You can find a guide on password protecting Word documents on the “Questions” section of my website.