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|  |  |
| --- | --- |
| **Surname** | **CLIENT DETAILS** |
| **First name** |  |
| **Date of birth** |  |
| **Address** |  |
|  |  |
|  |  |
|  |  |
| **Postcode** |  |
|  |  |
| **Tel number (mobile)** |  |
| **Tel number (other)** |  |
|  |  |
| **Email address** |  |
|  |  |
| **How did you hear about us?** |  |
|  |  |
| **Doctor’s details:** |  |
| **Name** |  |
| **Address** |  |
|  |  |
|  |  |
|  |  |
| **Telephone number** |  |
|  |  |

*I confirm that I have read and understood all the information detailed in the Client Information Sheet and that I agree to abide by the terms and conditions outlined therein.  In addition I also give my permission for my therapist to make contact with the appropriate external agencies if he or she believes that I am a danger either to myself or others.*

|  |  |
| --- | --- |
| **Signed** |  |
|  |  |  |
| **Date** |  |  |