Tiny Seeds
FERTILITY SUPPORT AND AWARENESS

Client Pre-Assessment Form

(To be completed by the client before being assigned a student counsellor)

Client Details

• Full Name: _____

• Date of Birth: _____ Age: _____

• Contact Information: _____

• Emergency Contact Name & Number: _____

Referral Information

How were you referred to our service? (Please tick one)

☐ Self-referral

☐ GP/Healthcare Professional

☐ Charity Support Worker

☐ Other (please specify): _____

Presenting Issues

What issues are you currently experiencing? (Please tick all that apply)

☐ Anxiety

☐ Depression

☐ Stress

☐ Bereavement

☐ Relationship Issues

☐ Low Self-Esteem

☐ Trauma (mild to moderate)

☐ Work/Financial Stress

☐ Other (please specify): _____

Risk Assessment

Please answer the following questions:

• Are you currently experiencing suicidal thoughts? ☐ Yes ☐ No

• Do you have a history of self-harm? ☐ Yes ☐ No

• Do you have any safeguarding concerns (e.g., domestic abuse, exploitation)? ☐ Yes ☐ No

• Do you have any concerns regarding substance use? ☐ Yes ☐ No

Mental Health History

• Have you ever been diagnosed with a severe or complex mental health condition (e.g. bipolar disorder, schizophrenia, personality disorder)? ☐ Yes ☐ No

• If yes, please provide details:

_____

_____

Previous Therapy Experience

• Have you received counselling before? ☐ Yes ☐ No

• If yes, when and what type? _____

Additional Notes

(Please use this space to provide any further relevant information)

Date: _____