Sandie Crowe
Psychodynamic Therapy & Counselling
Tel: 07376 182543

CLIENT PERSONAL DETAILS

PLEASE COMPLETE THE DETAILS BELOW:

NAME : ……

ADDRESS:

……

……

……..

POST CODE: ……..TELEPHONE NO: ……..

DATE OF BIRTH: ……

GENDER : MALE ☐ FEMALE ☐

MAY I CONTACT YOU BY PHONE? YES ☐ NO ☐

CAN I CONTACT YOU BY E-MAIL? YES ☐ NO ☐

PLEASE SUPPLY AN E-MAIL ADDRESS: ……

GP DETAILS:

NAME OF GP:……

SURGERY NAME: ……..

ADDRESS:……

……

POSTCODE: ……

TELEPHONE NUMBER: ……..

DATA PROTECTION:

To comply with the Data Protection Act 2018 I need you to be aware of how I use and protect your information.

- Your client records are kept filed in a locked cabinet inaccessible to the public or, unauthorised persons. Any computerised records will be encrypted and password protected. All information will remain confidential unless there is a moral or, legal obligation to disclose.
- As a qualified counsellor it is a mandatory requirement by my professional body (BACP) to attend regular clinical supervision whereby I will present and discuss our work. Your identity will be protected during consultation.
- I will ensure that your information is kept to a minimum, is factual and up to date.
- Your client records will be securely destroyed 3 years after the end of the current counselling relationship.

I confirm I have read the statements above and I give my permission for my personal information to be used, including my telephone number and e-mail, for the duration of my therapy.

Signature :