**Saffron - Sheffield Women’s Counselling and Therapy Service  
Client Registration Form**

|  |
| --- |
| **Saffron reference:** |

To join our waiting list you need to complete and return this registration form *(we’ve provided a stamped addressed envelope)*. **The deadline for returning your completed form is 30th June we will not process forms received after this date; you will need to wait until we open the waiting list again.** Complete as much of the form as you can. If you have problems we can help you to fully complete the form at your first appointment.

1. **Your contact details: complete *all* the boxes - tick, circle or delete, as appropriate for how we contact you - and remember to let us know if you change any of your contact details**

|  |  |  |
| --- | --- | --- |
| **Letter** *(we need your full address even if you prefer that we don’t write to you)* |  | Are you happy for us to write to you? **Y / N** |
| **Mobile phone**: |  | Would you prefer us to **call** or **text** you? Is it ok to leave a message if we call you? **Y / N** |
| **Email**: |  | Are you happy for us to contact you by email? **Y / N** |
| **Home phone**: |  | Is it ok to contact you on your home phone? **Y / N** Is it ok to leave a message? **Y / N** |

1. **I am generally available to attend regular weekly appointments on *(indicate all that apply)****:*

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **AM** | **Mon** |  | **Tues** |  | **Weds** |  | **Thurs** |  | **Fri** |  |
| **PM** | **Mon** |  | **Tues** |  | **Weds** |  | **Thurs** |  | **Fri** |  |

**Appointments are generally between 9am and 5pm with the last appointment at around 4.00pm although we do have some evening appointments**.

1. **How old are you?** ………………… **What is your date of birth?** …………….……….........................
2. **Have you used our service before? NO** **YES** **if ‘yes’ when?** …………………………
3. **GP (Doctor)** - the name of your surgery or medical centre - and the name of your GP if you see a specific doctor:  
     
   ……………………………………………………………………………………………………………….

**Phone number** ……………………………………………………………………………………………..

1. **Your living situation**

|  |  |  |  |
| --- | --- | --- | --- |
| **I live alone** |  | **I live with other relatives/friends** |  |
| **I live with a partner** |  | **I live in temporary accommodation** |  |
| **I live with my parents or a guardian** |  | **I live in a hospital or care setting** |  |

**Do you have caring responsibilities?**

|  |  |  |  |
| --- | --- | --- | --- |
| **I care for a child/children under 5** |  | **I care for a child/children over 5** |  |
| **I care for another adult** |  | **Other** *(please specify)* | |

1. **What is your employment status? indicate whichever *best* describes your main occupation**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Employed full-time (30+hrs)** |  | **Employed part-time** |  | **Unemployed** |  |
| **Student** |  | **Carer** |  | **Volunteer** |  |
| **Retired** |  | **Other** *(please specify)* | | | |

1. **Benefits**: please note, below, if you are in receipt of any work-related benefits e.g. income support, incapacity benefit or statutory sick pay

|  |
| --- |
|  |

1. **Why you want our service**:we are a specialist service for women in Sheffield who have experienced/are experiencing complex trauma and/or abuse. Please indicate, below, the issues you have/are experiencing ***indicate as many as apply to you***

|  |  |  |  |
| --- | --- | --- | --- |
| **Sexual abuse, exploitation or rape as a child or young adult** |  | **Domestic abuse** | |
| **Sexual abuse, exploitation or rape as an adult** |  | **physical** |  |
| **Depression, anxiety, stress or other mental ill health** |  | **mental/emotional** |  |
| **Substance misuse** |  | **financial** |  |
| **Alcohol misuse** |  | **controlling (coercive) behaviour** |  |
| **Self harm** |  |  |  |
| **Suicidal thoughts** |  |  |  |
| **Suicide attempt** |  |  |  |

1. **Have you seen a counsellor / therapist previously - if so, where? *indicate as many as apply***

|  |  |  |  |
| --- | --- | --- | --- |
| **Your GP** |  | **Your workplace** |  |
| **College/University** |  | **In a voluntary organisation** |  |
| **Have you had care/support for emotional / psychological difficulties from any of the following? *indicate as many as apply*** | | | |
| **Community Mental Health Team** |  | **Psychiatric care** |  |
| **Specialist psychological therapy/treatment** |  | **Hospital day care** |  |
| **Hospital admission** |  | **Other** *(please specify)* | |

1. **Are you currently being prescribed medication for emotional or psychological problems?**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Anti-depressants** |  | **Anxiolytics (for anxiety)** |  | **Anti-psychotics** |  |
| **Other** *(please specify)* | | | | | |

*The following questions help us to make sure that we provide the best service for all our clients and that we don’t discriminate against any section of our community*

1. **Gender**

|  |  |  |  |
| --- | --- | --- | --- |
| **Female** |  | *or* **I live and work permanently in a gender other than assigned at birth** |  |

**Sexual orientation**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Heterosexual** |  | **Lesbian** |  | **Bisexual** |  | **Prefer not to say** |  |

1. **How would you describe your race/ethnicity?**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **WHITE** | **British** |  | **Irish** |  | **European** |  | **Gypsy/Traveller/ Roma** | |  |
| **BLACK** | **British** |  | **African** |  | **Caribbean** |  | **Other** *(please specify)* | | |
| **ASIAN** | **British** |  | **Indian** |  | **Pakistani** |  | **Bangladeshi** | |  |
| **ASIAN** | **Chinese** |  | **Other** *(please specify)* | | | | | | |
| **MIXED** | **White and Black Caribbean** |  | **White and Black African** |  | **White and Asian** | **Other** *(please specify)* | | | |

1. **How would you describe your religion/beliefs?**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Christian** |  | **Islam** |  | **Judaism** |  | **None** |  | **Other** *(please specify)* |
| **Buddhism** |  | **Hinduism** |  | **Sikhism** |  | **Prefer not to say** |  |

1. **Do you consider that you are affected by any of the following? *indicate as many as apply***

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Impaired** | | | | **Other** | | | |
| **Mobility** |  | **Vision** |  | **Learning difficulties** |  | **Mental ill health** |  |
| **Hearing** |  | **Speech** |  | **A long term illness or condition** | | |  |
| **Do you need a ground floor room?** | | | | | | | |
| **I do NOT have a disability** | | |  | **I prefer not to say** |  |  | |

1. **What is your first / main language?**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **English** |  | | | **Other** *(please specify)* | | | |
| **How well can you speak English?** | | | | | | | |
| **Very well** |  | **Well** |  | **Not well** |  | **Not at all** |  |

**17. How did you hear about our service?..................................................................................**

|  |
| --- |
| **Data Protection Act 1998**: the personal data collected on this form will be kept secure and confidential within SWCTS. Your personal data will only be used for the purpose of client support and monitoring within SWCTS. This information will never be disclosed to any external sources without your express consent. SWCTS does share anonymised and unidentifiable information with funders in support of our work. **To comply with the Data Protection Act it is essential that you give your consent by signing below.**  **I give my permission for Sheffield Women’s Counselling and Therapy Service to hold the information given on this form about myself.**  **Name (print) ………………………………………………. Signature ………………………………………….**  **Date …………………………………………………………** |

*Thanks for completing this form; please return it to Saffron Sheffield, 44 Daniel Hill, Sheffield S6 3JF in the stamped, addressed envelope provided. When we receive this form you will be added to our waiting list. We will contact you as soon as an appointment becomes available. If you have any queries you can call us on 0114 275 2157; call/text us on 07742 533 603; or email us at* [*office@saffronsheffield.org.uk*](mailto:office@swcts.org.uk)