

Yorkshire Counselling Services  
**PRIVATE AND CONFIDENTIAL**

*This information will not be shared with any other agencies unless we jointly agree or there is concern for your safety or the safety of others.*

<b><u>NEW CLIENT INFORMATION</u></b>		
Client Number :	<b>Partner 1</b>	<b>Partner 2</b>
<i>Name:</i>		
<i>Address:</i>		
<i>Contact details: Phone no: Email:</i>		
<i>Date of Birth:</i>		
<i>Number and age of children:</i>		
<i>Name and address of GP:</i>		
<i>Other relevant medical or health information:</i>		

## Yorkshire Counselling Services

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### Patient Health Questionnaire (PHQ9)

**PARTNER 1:**

**Date:**

**Over the last 2 weeks, how often have you been bothered by any of the following problems?**

*Please only check one box per line*

		Not at all	Several days	More than half the days	Nearly every day
1	Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Trouble falling or staying asleep, or sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	Feeling bad about yourself or that you are a failure or have let yourself or your family down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	Moving or speaking so slowly that other people could have noticed. Or the opposite being so fidgety or restless that you have been moving around a lot more than usual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	Thoughts that you would be better off dead, or of hurting yourself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>TOTAL</b>					
<i>For counsellor use only</i>					

## Patient Health Questionnaire (PHQ9)

**PARTNER 2:**

**Date:**

**Over the last 2 weeks, how often have you been bothered by any of the following problems?**

*Please only check one box per line*

		Not at all	Several days	More than half the days	Nearly every day
1	Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Trouble falling or staying asleep, or sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	Feeling bad about yourself or that you are a failure or have let yourself or your family down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	Moving or speaking so slowly that other people could have noticed. Or the opposite being so fidgety or restless that you have been moving around a lot more than usual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	Thoughts that you would be better off dead, or of hurting yourself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>TOTAL</b>					
<i>For counsellor use only</i>					