



CHRISTINE COPLEY
REGISTERED COUNSELLOR

BA Hons (BPsych Equivalent) Cum Laude
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Thank you for enquiring about counselling.

Kindly complete the information below to enable me to establish whether we will be a good fit for a therapeutic intervention:

(Note: To fill out this pdf form, click on "Tools" on the menu bar, and then "Fill & Sign")

Name:	Surname:
Date of birth:	Language:
Referral: Self/Parent/Professional/Other:	

Seeking:

- Individual counselling
- Couples counselling
- Family counselling

Please tick the reason/s for seeking counselling:

<input type="checkbox"/> Abortion <input type="checkbox"/> Absent Parent <input type="checkbox"/> Abuse – physical <input type="checkbox"/> Abuse – sexual <input type="checkbox"/> Abuse – emotional <input type="checkbox"/> Abuse - neglect <input type="checkbox"/> Anger <input type="checkbox"/> Anxiety/Stress <input type="checkbox"/> Attention <input type="checkbox"/> Behavioural problems <input type="checkbox"/> Bullying <input type="checkbox"/> Career Guidance <input type="checkbox"/> Childhood issues <input type="checkbox"/> Chronic Illness <input type="checkbox"/> Concentration <input type="checkbox"/> Communication <input type="checkbox"/> Conflict <input type="checkbox"/> Dating/Relationship issues <input type="checkbox"/> Depression/Sadness <input type="checkbox"/> Disordered eating	<input type="checkbox"/> Divorce <input type="checkbox"/> Family problems <input type="checkbox"/> Fatigue/Low energy <input type="checkbox"/> Friends/Peers/Social life <input type="checkbox"/> Financial Problems <input type="checkbox"/> Fearfulness <input type="checkbox"/> Gender/Sexuality/ Identity <input type="checkbox"/> Goals <input type="checkbox"/> Grief/Loss <input type="checkbox"/> Health <input type="checkbox"/> Infidelity <input type="checkbox"/> Life coaching <input type="checkbox"/> Loneliness <input type="checkbox"/> Marital/Partner issue <input type="checkbox"/> Motivation <input type="checkbox"/> Overwhelm <input type="checkbox"/> Panic attacks <input type="checkbox"/> Pregnancy/Miscarriage/ Infertility	<input type="checkbox"/> Parenting <input type="checkbox"/> Relationship between parents <input type="checkbox"/> Relationship with parents <input type="checkbox"/> Relationship with siblings <input type="checkbox"/> Self-esteem <input type="checkbox"/> Sleep disturbance <input type="checkbox"/> School <input type="checkbox"/> Sadness <input type="checkbox"/> Self-care <input type="checkbox"/> Self-harm <input type="checkbox"/> Suicidal thoughts/ Behaviour <input type="checkbox"/> Substance Abuse - Drugs <input type="checkbox"/> Substance Abuse - Alcohol <input type="checkbox"/> Time Management <input type="checkbox"/> Trauma <input type="checkbox"/> Work <input type="checkbox"/> Other:
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Provide a brief description of the situation:

Are you currently seeing a psychiatrist or psychologist? YES / NO

If yes, please indicate if a particular diagnosis has been confirmed:

Name of psychologist/psychiatrist:

Please return this completed form to: chriscopleyrc@gmail.com.

Kind regards,

Christine Copley