Highgate Counselling Centre

COUNSELLING REGISTRATION FORM

1. Name: _____
2. Date of Birth: _____
3. Address: _____

   _____ Post Code_____
4. Email Address: _____
5. Telephone: Day: _____

   Evening: _____

   Mobile: _____

Can messages be left for you on your answerphone? Yes / No

Can messages be left with whoever answers the phone? Yes / No

Can messages be left at work? Yes / No

6. Employment: (please tick which applies)

More than 30 hours_____ Less than 30 hours a week_____ Receiving Sickness Benefit_____

Incapacity Benefit_____ Invalidity Benefit_____Unemployed_____Student Full-time_____

Student Part time_____Retired_____Houseperson_____Other_____

7. Name of your GP_____

   Telephone:_____

   Address:_____

   _____

(We require these details in case of an emergency but will not approach your GP without discussing it with you first)

8. Availability for counselling: (please tick)

   Weekday morning 9am to 12pm _____ Weekday afternoon 1pm to 5pm _____

   Weekday evening 6pm to 9pm _____ Saturday morning 9am to 1pm _____

9. Where did you hear about Highgate Counselling Centre?

_____

I confirm the above application

Name _____

Signature _____

Date: _____

Please email this form to admin@highgatecounselling.org.uk and we will contact you to arrange an initial Consultation