

FAMILY COUNSELLING REGISTRATION FORM

FC	£	
FC Assessment date -	DO YOU WORK FOR LEEDS TEACHING HOSPITAL YES/NO -	

Client 1 - Callers Name		Client 2 Name -			
Address		Address			
		Email - Client 2			
Postcode	Does Client 2 know about enquiry?	Yes	No	Unclear	NA
Tel: home	Is Client 2 coming with caller?	Yes	No	Unclear	
Work	Has any member of the family been to Relate before?			Yes/No	
Mobile	If yes, in what year?				
Email – Client 1	If yes, which Relate service?				

Who else is coming to the Assessment?		(put age of children if under 16)		
Name		M / F	Age	Relationship to enquirer
Tel No				
Address				
Name		M / F	Age	Relationship to enquirer
Tel No				
Address				
Name		M / F	Age	Relationship to enquirer
Tel No				
Address				
Name		M / F	Age	Relationship to enquirer
Tel No				
Address				

If you have an answer phone, may we leave a message? Yes/No
 Can we contact you by email? Yes/No
 Is anyone attending an appointment that is registered disabled? Yes/No
 If so, please give details of any special requirements you may have

Please X below to indicate when you are available to come for your meeting with a counsellor. .

DAY	TIME	Tick Box	TIME	Tick Box
Monday	9.30-12.30 AM			
Tuesday	10.30-11.30 AM		2.30PM – 7.00PM	
Thursday	9.30 -1.15 PM			

I/We request that you register me/us as RELATE clients & arrange an Initial Appointment for me/us as soon as possible. I/We enclose a pre-payment of £..... **(Please note that you will be charged for appointments not kept or cancelled within 48 hours notice).**

Signed Signed..... Date.....
 Return completed form to:- Relate, Oxford Chambers, Oxford Place, Leeds, LS1 3AX.
 Or email to:- <mailto:info@relateleeds.org.uk>