1) Basic Information

Client code	
Client name	
Date of assessment	
Name of assessor	

Are the contact details correct? ☐

2) How are you feeling?

This form has 10 statements about how you have been OVER THE LAST WEEK. Please read each statement and think how often you felt that way last week. Then tick the box which is closest to this.

Over the last week …		Not at all	Only occasionally	Sometimes	Often	Most or all of the time
1	I have felt tense, anxious or nervous	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
2	I have felt I have someone to turn to for support when needed	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
3	I have felt able to cope when things go wrong	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
4	Talking to people has felt too much for me	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
5	I have felt panic or terror	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
6	I have made plans to end my life	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
7	I have had difficulty getting to sleep or staying asleep	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
8	I have felt despairing or hopeless	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
9	I have felt unhappy	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
10	Unwanted images or memories have been distressing me	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

3) About the abuse

Type of abuse

☐ (1) Childhood sexual abuse ☐ (2) Rape ☐ (3) Domestic abuse

☐ (4) Sexual assault ☐ (5) Grooming ☐ (6) Stalking

☐ (7) Harassment ☐ (8) Childhood non-sexual abuse

☐ (9) Trafficking ☐ (0) Ritual abuse

Relationship to abuser

☐ Partner ☐ Ex partner ☐ Parent ☐ Stepparent/partner of parent

☐ Other relative ☐ Authority figure ☐ Family friend ☐ Acquaintance

☐ Stranger ☐ Multiple perpetrators

At what age did the abuse start?	
At what age did the abuse finish?	

How long ago was the most recent abuse?

☐ Within 7 days ☐ 7 days to 6 months ☐ 6 months to 1 year ☐ 1-5 years

☐ 5 years plus

Have there been multiple incidents of abuse? ☐

Why and when did the abuse finish or is it continuing?

Further notes about the abuse

4) Family and relationships

Do you have support from your family or partner?

Do you have children? If so comment on ages, relationship with children and whether there are any anxieties about keeping the children safe. Also record if Children's Services are involved.

Do you have friends who you can talk to and who are supportive?

5) Emotional health

Do you have any mental health diagnosis?

☐ PTSD	☐ Depression	☐ Extreme anxiety
☐ Panic attacks	☐ Flashbacks	☐ Triggers
☐ DID	☐ Losing time	☐ Withdrawing from here and now
☐ Anger	☐ Emotional distress	☐ Expressing high levels of distress
☐ Concentration issues	☐ Nightmares	☐ Issues with sleep

Comments

Have you had suicidal feelings in the past?

☐ Recent suicide attempts	☐Historical suicide attempts	☐ No previous suicide attempts

How are you feeling now?

☐No suicidal feelings	☐Helplessness/hopelessness/feel life is not worth living
☐ Expressed suicidal ideation	☐ Definite, realistic plan of suicide

Further comments about suicidal feelings and actions

Self-esteem

☐ Low self-worth or low self-esteem (as a result of incident)

☐ Client blames themselves for what happened

☐ Poor assertiveness

Comments

6) Coping strategies

	Yes	Potential	Past
Alcohol misuse			
Drugs misuse			
Gambling			
Eating disorder			
Self-harm			
Obsessive behaviours			
Other dependencies			

Comments

Positive coping strategies (e.g. friends, family, music, books, pets, hobbies)

7) Support work needs

What are your feelings around safety?

☐ Don't feel safe inside own home ☐ Don't feel safe outside home
☐ Only go out accompanied ☐ Particular times/situations when I don't feel safe – please give more details

Comments

Thinking about day-to-day living, are you:

☐ Not eating healthily ☐ Having difficulty sleeping ☐ Sleeping too much
☐ Unable to get out of bed ☐ Having issues with self-care ☐ Unable to carry out everyday tasks

Comments

Are you currently unemployed?

☐ Yes ☐ No

Comments: Please provide details of how long the client has been unemployed and whether their experiences of abuse have contributed to unemployment

Are there issues with:

☐ Housing or accommodation ☐ Finances ☐ Benefits ☐ Legal issues

Comments

Support worker referral required? If yes then please complete this.

☐ Yes ☐ No

8) Aspirations

What would you like to achieve through coming to us?

9) Previous and current professional support

GP	
Mental health services and/or community psychiatric nurse	
Social services and/or social worker	
Leeway / DV services	
Housing officer / council	
Children's Services	
IDVA	
ISVA	
Other	

Have you previously received or been offered therapy? If so, who with and did you find it beneficial?

☐ Yes ☐ No

Comments

10) Relevant medical information

Do you currently take any medication of which we need to be aware? For how long? What dosage?

Do you have any disabilities or any special needs?

Are there any other issues relating to your health that we need to be aware of?

11) Police involvement

Have the experiences that led the client to seek support from the Sue Lambert Trust been:

☐ Reported to the police ☐ Thinking about reporting in the future

☐ No plans to report ☐ Not applicable

If a report has been made, is the case:

☐ Currently under investigation ☐ Closed, case not progressed

☐ Closed, guilty verdict ☐ Other

Comments

12) Risk assessment

	Yes	Potential	Past
Risks to children			
Risks to vulnerable adults			
Domestic violence			
Stalking			
Honour based violence			
Sex worker			
Exploitation			
High suicide risk			
Other vulnerability			

If yes or potential to any of these questions, a separate risk assessment may need to be carried out.

Comments

12) Keeping in contact

Are you happy to receive review calls?

☐ Yes ☐ No

Comments

13) Clinical Assessment

General Comments

Therapy recommendations – counsellor level

☐ No service suitable for client ☐ Suitable for TRAINEE

☐ Suitable for QUALIFIED ☐ Suitable for EXPERIENCED

If client is not suitable for therapy, please outline the reasons:

Suitable for long-term counselling?

☐ Yes ☐ No

Suitable for therapy group?

☐Yes ☐ No

Face-to-face work suitable for this client?

☐ Yes ☐ No

Remote work suitable for this client?

☐ Yes ☐ No

Practical support work recommendations: if yes then please complete a support work referral form

☐ Yes ☐ No

Groundwork (stabilisation with Sue/Julie) recommendations: if yes then please complete a Groundwork referral form

☐ Yes ☐ No

Would like information on the self-help groups

☐ Yes ☐ No

DASH assessment needed: If yes please complete DASH assessment form

☐ Yes ☐ No

Referral to other agency or MARAC

☐ Yes ☐ No

For use by Clinical Lead or Second Assessor:

I agree with the above assessment

☐ Yes ☐ No

Notes