**Client’s Details**

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| --- | --- |
| **First Name(s):** |  |
| **Last Name:** |  |
| **Date of Birth:** |  |
| **Address:** |  |
| **Telephone No.:** |  |
| **Email Address:** |  |
| **Communication**  **Requirements/ Preferences:** |  |
| **Where did you hear about us?** | *Website  Friend/ family  GP   Professional  Other* |

**Referrers Details (if applicable)**

|  |  |
| --- | --- |
| **Name/Agency** |  |
| **Referrer:** |  |
| **Contact number/ email** |  |

**Please answer the following questions:**

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| 1. **Do you have a Long-Term Health Condition?** Yes  No   If so, what is it? 2. **Are you an unpaid Carer?** Yes  No 3. **Do you have any diagnosed Mental Health Illness?** Yes  No 4. **What type of support and advice would you like to receive from this service?** 5. **Are there any immediate concerns about your health and wellbeing that you would like us to know about?** Yes  No  If so, please describe. 6. **Are you receiving any health and social care support from Enfield Council**?  Yes  No |

**Is there any other information we need to be aware of?**

*(e.g., risks, safeguarding, etc)*

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