## Client (Young Person) Details

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
School/College (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Parent/Guardian Details

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Relationship to Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Emergency Contact (if different): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Therapy Details

Therapist Name: Sue Dixon  
Therapy Provided: Clinical Hypnotherapy / Grief Support / Counselling  
Sessions Held: In person / Online  
Duration: Approx. 50 minutes per session  
Confidentiality: Sessions are confidential between the young person and the therapist. However, if there are concerns about the young person's safety or wellbeing, information may need to be shared in accordance with safeguarding policies.

## Consent Statement

I confirm that I am the parent/legal guardian of the above-named young person. I give permission for them to receive therapy with Evolve Talking Therapies. I understand the nature and purpose of the sessions and acknowledge that I have had the opportunity to ask questions.  
  
I understand that:  
- The therapist will maintain confidentiality with the young person unless there are safeguarding concerns.  
- I may be contacted in the event of a concern or risk to the young person's safety.  
- I may be asked to participate in part of the therapeutic process if deemed helpful and appropriate.  
- I can withdraw my consent at any time by contacting the therapist in writing.

## Signatures

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Young Person Signature (if appropriate): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Therapist Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Contact Information

If you have any questions or would like to discuss anything before giving your consent, please contact Sue at:  
  
Email: evolvetth@gmail.com  
Phone: 07769 102201  
Website: www.evolvetalkingtherapies.co.uk