Dr Paul Bibby, BSc, D Clin Psychol

Chartered Clinical Psychologist, HCPC Registered Practitioner Psychologist

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**Client Data form**

|  |  |
| --- | --- |
| 1. About You |  |
| Full name |  |
| Name you prefer to be called |  |
| Date of birth  (DD/MM/YYYY) |  |
| Home address |  |
|  |  |
|  |  |
| Postcode |  |
| Telephone contacts (provide **only** those you would be happy to be contacted on) and indicate which are OK to leave a voicemail | |
| Home | OK to leave VM? |
| Mobile | OK to leave VM? |
| Work/college/university | OK to leave VM? |
| Email address |  |

***Please turn over to provide GP and Emergency Contact details***

|  |  |
| --- | --- |
| 1. GP Details |  |
| Name of GP Practice where you are registered |  |
| GP Practice address |  |
|  |  |
|  |  |
| Postcode |  |
| Telephone |  |
| Name of GP registered with (if known) |  |

|  |  |
| --- | --- |
| 1. Emergency contact details | |
| Name |  |
| Address |  |
|  |  |
|  |  |
| Postcode |  |
| Telephone |  |
| Home |  |
| Mobile |  |
| Work/college/university |  |

|  |  |
| --- | --- |
| 1. Consent to Share Information | |
| *I give my permission for Dr Paul Bibby to discuss my care with the following individuals/representatives of organizations:* | |
| Named Person #1 |  |
| Named Person #2 |  |
| Named Person #3 |  |
| *I understand that I can withdraw this consent to share at any time by informing my therapist.* | |
| Client Name | Signed Date |
| Therapist Name | Dr Paul Bibby Signed Date |