Please save this form to your Desktop, complete the relevant details, and email to:
info.cornerstone@googlemail.com

SELF REFERRAL FORM

I am asking for

Name

Street Number and Name
(Address is Optional)
Town

Postcode

Contact number

E-mail Address

1) Please tick one or more of the following that you feel are affecting you

Depression

Anxiety

Loss and bereavement

Anxiety, stress, anger

Personal development

Eating issues

Self-esteem and confidence

Work-related problems

Relationship Counselling (for individuals and couples of any orientation)

Sexual therapy (for individuals and couples of any orientation)

Family counselling

Young person's counselling

Coaching

EMDR for post-trauma difficulties

2) How long have you been experiencing these difficulties/issues?

Background Information (optional)

3) What are your preferred days to see a Therapist?
Mon

Tues

Wed

Thurs

Fri

Sat

4) Times

5) If you have looked at our therapists profiles do you have any preferences?
A

B

C
No problem if not

6) When is the best time to contact you?

7) Preferred method of contact
Text

Phone

Email

8) Is it ok to leave a message on your
Home phone

Mobile phone

9) Where did you hear about us?

Please Note:
Cornerstone with keep all information, supplied by you on this form, securely. Cornerstone will not pass your information onto third parties.
Yes, keep my information

No, do not keep my information