

CAIRNS COUNSELLING CENTRE

CONFIDENTIAL

Name.....

Postcode.....

How did you hear about us?

Tel. Mobile..... Home.....

Work..... Date of Birth.....

Medical Practice
.....

Please circle days and times when you would be available to attend counselling sessions. NB These would usually be at the same time each week.

Monday	Tuesday	Wednesday	Thursday	Friday
10am-1pm	10am-1pm	10am-1pm	10am-1pm	10am-1pm
2pm-5pm	2pm-5pm	2pm-5pm	2pm-5pm	2pm-5pm
5pm-8pm	5pm-8pm	5pm-8pm		

Female counsellor.....	Male counsellor	No preference
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Additional information you feel may be helpful to us about your present situation: