CGST COUNSELLING CENTRE
CARIBBEAN GRADUATE SCHOOL OF THEOLOGY
18 West Avenue, Kingston 8
(876) 832 - 2898
Email: tccdirector@cgst.edu.jm

Counselling Intake Form

Personal Information

- Full Name: _____
- Date of Birth: _____
- Gender: _____
- Contact Number: _____
- Email Address: _____
- Preferred Method of Contact: ☐ Phone ☐ Email ☐ Other: _____

Emergency Contact

- Name: _____
- Relationship: _____
- Contact Number: _____

Reason for Seeking Counselling
Please briefly describe the issues or concerns you would like to address:

_____

_____

Relevant Medical or Mental Health History

- Current medications: _____
- Past mental health treatment: ☐ Yes ☐ No (If yes, please specify)
- Relevant medical conditions: _____

Goals for Counselling
Please indicate what you hope to achieve through counselling:

_____

_____

Confidentiality Acknowledgment
I understand that information provided in this form and during counselling sessions is confidential and will only be shared with others with my consent, except in situations required by law.
Signature: _____ Date: _____