Integrated Treatment Services
Client-centred Therapy

Meeting Record Form

Client Name: _____ **D.O.B:**_____

Date of Meeting: _____ **Venue:**_____

Start time: _____ **Finish time** _____

Reason for meeting:	
Present:	**Apologies:**
Matters discussed	

Meeting outcomes:

AT actions:

Signature of Therapist: ______________________________________ **Date:** ____________
Date notes recorded: ______________ **Start time:** __________ **Finish time:** __________

Arts Therapist
Integrated Treatment Services