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COUNSELLING INTAKE INFORMATION

Date: _____

Please provide the following information. All information provided will comply with the federal *Privacy Act 1988*, the NSW *Privacy & Personal Information Protection Act 1998*, or both. The intent of use is to provide brief assessment information to our counsellors.

Name: _____

Date of Birth _____ AGE: _____

Address: _____

Home Phone: _____ May we leave a message? Yes No

Mobile Phone: _____ May we leave a message? Yes No

Email Address: _____ May we email you? Yes No

(Please note email might not be confidential)

Referred by: _____ Organisation: _____ Phone: _____

Emergency Contact:

Name: _____

Contact Number: _____

Relationship: _____

Have you seen a counsellor/psychologist in the past?

Yes No

Can you remember the year? _____

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Do you have a diagnosed mental health condition?

Yes No

If yes, please list.

Do you have a General Practitioner?

Yes No Name: _____ Suburb: _____

Please list any psychiatric medication/s you are currently taking.

On a scale of 1-10, how would you rate your mood? (1 = very low and 10 = very high)

1 2 3 4 5 6 7 8 9 10

What is the nature you are seeking Counselling?

- | | | | |
|-------------------------|--------------------------|---------------------------------------|--------------------------|
| Depression | <input type="checkbox"/> | Anxiety; Social Phobia; Panic Attacks | <input type="checkbox"/> |
| Legal | <input type="checkbox"/> | Anger management | <input type="checkbox"/> |
| Alcohol/Substance Abuse | <input type="checkbox"/> | Trauma | <input type="checkbox"/> |
| Grief & Loss | <input type="checkbox"/> | Schizophrenia | <input type="checkbox"/> |
| Eating Disorder | <input type="checkbox"/> | Suicide Attempts | <input type="checkbox"/> |
| Bipolar Disorder | <input type="checkbox"/> | Relationship Breakdown | <input type="checkbox"/> |
| Domestic Violence | <input type="checkbox"/> | Emotional support | <input type="checkbox"/> |
| Employment-related | <input type="checkbox"/> | Housing-related | <input type="checkbox"/> |
| Unsure / indeterminate | <input type="checkbox"/> | Sexuality | <input type="checkbox"/> |

Other: _____

What you would like to achieve through counselling? List if more than one reason.

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