1 Bedford St (PO Box 19) Newtown NSW 2042 Ph: 9564 7333 Fax: 9519 2509
Email: admin@newtowncentre.org Website: www.newtowncentre.org ABN: 96 884 462 833

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	☐	Anxiety; Social Phobia; Panic Attacks	☐
Legal	☐	Anger management	☐
Alcohol/Substance Abuse	☐	Trauma	☐
Grief & Loss	☐	Schizophrenia	☐
Eating Disorder	☐	Suicide Attempts	☐
Bipolar Disorder	☐	Relationship Breakdown	☐
Domestic Violence	☐	Emotional support	☐
Employment-related	☐	Housing-related	☐
Unsure / indeterminate	☐	Sexuality	☐

Other: _____

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

_____

_____