Davina Counselling & Psychotherapy – Intake Form

Supporting children, young people, and families with care and clarity

Client Details

Name: _____

Date of Birth: _____

Preferred Name: _____

Pronouns: He/Him She/Her

Parent/Carer Name (if applicable): _____

Relationship to child: _____

- Contact Number: _____
- Email: _____
- Address: _____

  _____
- Emergency Contact Name & Number: _____

  _____
- GP Name & Clinic: _____

  _____

Mental Health History

Please share anything you feel comfortable disclosing. This helps us understand your journey and tailor support to your needs.

- Has your child ever been diagnosed with a mental health condition?

  ☐ Yes ☐ No ☐ Unsure If yes, what was the diagnosis? _____
- Has your child ever been hospitalised for mental health reasons? ☐ Yes ☐ No ☐ Unsure

  If yes, can you share the reason for admission? _____
- Has your child received a Mental Health Care Plan from a GP? ☐ Yes ☐ No ☐ Unsure
- Has your child experienced any of the following? (tick all that apply)

  ☐ Anxiety ☐ Depression ☐ Trauma/PTSD ☐ Eating concerns ☐ Mood changes ☐ Panic attacks ☐ Self-harm ☐ Suicidal thoughts

  ☐ Other (please specify): _____

- Has your child ever made a suicide attempt? ☐ Yes ☐ No If yes, how long ago?
- Is your child currently experiencing thoughts of suicide or self-harm? ☐ Yes ☐ No

  ☐ Prefer not to say If yes, would you like support with this today?_____
- Has your child had any experiences with addiction or compulsive behaviours?

  ☐ Alcohol ☐ Drugs ☐ Gambling ☐ Gaming ☐ Social media ☐ Pornography ☐ Other:
  Would you like support with this?_____
- Does your child currently use recreational drugs or alcohol? ☐ Yes ☐ No

  If yes, please describe:_____
  _____
  _____
  _____

Past Counselling & Support

- Has your child had counselling or psychological support in the past?

  ☐ Yes ☐ No ☐ Unsure
- If yes, please describe: When? Where? _____

  How long?_____
- What was the focus of the counselling?_____

  _____
- Do you recall any therapeutic approaches used (e.g., CBT, play therapy, EMDR)?_____
- What did your child find helpful or unhelpful?_____

  _____

  _____
- What brings your child to counselling now? _____

  _____
- What would you like your child to experience that feels different from their current situation? _____

  _____
- What would you like us to work on together? _____

  _____

Development & Family Context

- Are there any developmental concerns or diagnoses (e.g., autism, ADHD, learning differences)? _____

- Has your child experienced any significant changes (e.g., separation, grief, relocation)?

- Are there any cultural, spiritual, or family values you'd like us to be aware of?

- What are your child's strengths? What helps them feel safe or calm?

Any other information you would like us to know about your child?