Head 2 Heart
Psychology

Today's Date: ______________________________

CLIENT INFORMATION

Name: ______________________________

Address: ____

City:____________________ State: ____________ Postcode:_________

Email Address: ______________________________

Contact Telephone Numbers:

Home:________________________Can a message be left at this number? ☐ Yes ☐ No

Work:_________________________Can a message be left at this number? ☐ Yes ☐ No

Mobile:_______________________Can a message be left at this number? ☐ Yes ☐ No

Date of Birth:________________________

Gender: ☐ Male ☐ Female ☐ Other: ______________________________

Cultural Background:

☐ Aboriginal ☐ Neither Aboriginal nor Torres Strait Islander

☐ Torres Strait Islander ☐ Both Aboriginal and Torres Strait Islander

☐ Other: ____

MENTAL HEALTH INFORMATION

REASON FOR THERAPY:

Please indicate what has brought you to therapy so I can better understand your needs:

☐ Abuse	☐ Addiction	☐ ADHD
☐ Anger	☐ Anxiety	☐ Asperger's/Autism
☐ Bullying	☐ Depression	☐ Sleep Difficulties
☐ Grief/Loss	☐ Learning Problems	☐ Parenting Concerns
☐ Family Issues	☐ Relationship Issues	☐ Phobia
☐ Obsessions/Compulsions	☐ Panic	☐ Eating/Weight Issues
☐ Recent Trauma	☐ Past Trauma	☐ Thought Disturbance
☐ Self-Harm/Suicide	☐ Other:	

____

____

____

____

____

____

DIAGNOSES:

Have you ever been diagnosed with a mental health disorder/impairment? ☐ Yes ☐ No
If yes, please indicate diagnosis and year of diagnosis:

____________________ ____ ____________________ ____

____________________ ____ ____________________ ____

____________________ ____ ____________________ ____

SUPPORT CONTACT INFORMATION

EMERGENCY CONTACT INFORMATION:

If there is an emergency during the time you are under my professional care, or I become concerned about your personal safety, I am required by law and the rules of my profession to contact someone close to you (spouse, relative, close friend).

Name: ______________________________

Relationship to You: ______________________________

Address: ____

City: ____________________ State: ____________ Postcode: _________

Telephone Number: ______________________________

Email Address: ______________________________

OTHER PROFESSIONALS INVOLVED IN YOUR TREATMENT:

Medical Provider/Clinic Name: ____

Address: ____

City: ____________________ State: ____________ Postcode: _________

Telephone Number: ______________________________

Psychiatric Provider/Clinic Name: ____

Address: ____

City: ____________________ State: ____________ Postcode: _________

Telephone Number: ______________________________

Do you give your permission for them to be contacted for continuity of care? ☐ Yes ☐ No