Client Intake Form

General — New Client Registration

Healing Moments

Please complete this form before your first appointment. Your answers help your therapist understand your needs and provide the best possible care. All information is kept confidential and stored securely. If any question is difficult to answer, you may leave it blank and discuss it in session.

PERSONAL DETAILS

Full name:

Name you'd like to be called:

Date of birth: **Pronouns:**

Gender:

☐ Woman ☐ Man ☐ Non-binary ☐ Prefer to self-describe:

If relevant to your care, you are welcome to tell your therapist your sex assigned at birth in session.

Are you of Aboriginal and/or Torres Strait Islander origin?

☐ No ☐ Aboriginal ☐ Torres Strait Islander ☐ Both

Country of birth:

Cultural / ethnic background:

Language spoken at home:

Interpreter needed? ☐ No ☐ Yes

Occupation:

Address:

Suburb: **Postcode:**

Phone:

Email:

EMERGENCY CONTACT

Name:

Phone:

Relationship to you:

Do you live with other people or family? If yes, please list who:

MEDICAL & REFERRAL INFORMATION

Treating GP / medical doctor:

Address of treating doctor:

Do you have a referral? ☐ No ☐ Yes

If yes, please bring it to your first session or email it ahead of time.

TREATMENT HISTORY

Are you currently receiving psychiatric care, psychotherapy or counselling elsewhere?

☐ No ☐ Yes

If yes, reason for treatment:

Have you had mental health therapy in the past?

☐ No ☐ Yes

If yes, reason for treatment:

Have you ever been admitted to hospital for a mental health concern?

☐ No ☐ Yes

If yes, when and where:

Are you currently taking prescribed psychiatric medication (e.g. antidepressants, antipsychotics)?

☐ No ☐ Yes

If yes, please list medication and dose:

Prescribed by:

CURRENT DIAGNOSES

Have you been diagnosed with a mental health condition by a medical professional (psychiatrist or GP)?

☐ No ☐ Yes

If yes, please provide details:

LEGAL & COURT MATTERS

Do you have any current or pending court cases?

☐ No ☐ Yes

If yes, please provide details:

Will you require a letter from your therapist?

☐ No ☐ Yes

If yes, please provide details:

Do you have any current court orders you must comply with?

☐ No ☐ Yes

If yes, please provide details:

HEALTH & LIFESTYLE

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes):

Are you taking any medication for a physical health concern? If yes, please list:

Are you having any problems with your sleep? ☐ No ☐ Yes

If yes, tick where applicable:

☐ Sleeping too little ☐ Sleeping too much ☐ Poor quality sleep

☐ Disturbing dreams ☐ Other:

Exercise sessions per week: **How long each time?**

Are you having any difficulty with appetite or eating? ☐ No ☐ Yes

If yes, tick where applicable:

☐ Eating less ☐ Eating more ☐ Bingeing ☐ Restricting

Have you had a significant weight change in the last 2 months? ☐ No ☐ Yes

Do you drink alcohol regularly? ☐ No ☐ Yes

In a typical month, how often do you have 4 or more alcoholic drinks within 24 hours?

How often do you use recreational drugs?

☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never

Do you smoke cigarettes or use other tobacco / vaping products? ☐ No ☐ Yes

EMOTIONAL WELLBEING

These questions help your therapist understand how you have been feeling. If anything here raises something you would like immediate support with, please tell your therapist or, in an emergency, call 000 or Lifeline on 13 11 14.

Have you had thoughts of suicide recently?

☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never

Have you had thoughts of suicide in the past?

☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never

Have you ever intentionally hurt yourself without intending to end your life (e.g. cutting, burning)?

☐ No ☐ Yes ☐ Recently

Have you ever experienced any of the following? Please tick one column for each.

	No	Yes	Recently
Extreme depressed mood	☐	☐	☐
Dramatic mood swings	☐	☐	☐
Rapid or pressured speech	☐	☐	☐
Extreme anxiety	☐	☐	☐
Panic attacks	☐	☐	☐
Phobias	☐	☐	☐
Sleep disturbances	☐	☐	☐
Hallucinations	☐	☐	☐
Unexplained losses of time	☐	☐	☐
Unexplained memory lapses	☐	☐	☐
Alcohol or substance misuse	☐	☐	☐
Frequent physical complaints	☐	☐	☐
Eating disorder	☐	☐	☐
Body image problems	☐	☐	☐
Repetitive thoughts (e.g. obsessions)	☐	☐	☐
Repetitive behaviours (e.g. checking, hand-washing)	☐	☐	☐
Homicidal thoughts	☐	☐	☐
Suicide attempts	☐	☐	☐

If you have attempted suicide, when was this?

YOUR GOALS FOR THERAPY

What would you like to get out of therapy? What changes are you hoping for?

APPOINTMENTS & PUNCTUALITY

A consultation usually lasts 60 minutes. If you arrive late, your session will still finish at the scheduled time so that clients with later appointments are not kept waiting.

CONSENT TO SHARE INFORMATION

I, _____ , give permission for Healing Moments to obtain and exchange relevant written or verbal information with the following people / agencies:

☐ Treating referrer ☐ Psychiatrist ☐ GP ☐ Other:

_____

This consent remains valid until:

☐ I withdraw it in writing ☐ 12 months from signing ☐ Other:

_____

PRIVACY & COLLECTION NOTICE

Healing Moments collects the personal and health information on this form to provide you with psychological care, to maintain accurate clinical records, and to communicate with you about your appointments. Please be assured that your privacy, with regard to the use and storage of this information, will be respected in line with our Privacy Policy and the Australian Privacy Principles in the Privacy Act 1988 (Cth). Your information is kept confidential and stored securely, and will not be shared with anyone outside the practice without your consent, except where we are required or permitted by law (for example, where there is a serious risk to your safety or the safety of others). You may request access to your information or ask to correct it at any time.

DECLARATION & SIGNATURE

☐ I confirm I have been given access to the Healing Moments Client Agreement (available on the website or on request), and I understand my therapist will take me through it and answer any questions in my first session.

By signing below, I declare that the information I have provided is true and correct to the best of my knowledge. I consent to taking part in an initial assessment with Healing Moments, and I understand that I will have the opportunity to discuss and sign the Client Agreement before therapy continues. I understand that I am personally liable for the fees associated with this service.

Name: _____

Signature: _____

Date: _____