HEALING MOMENTS GENERAL INTAKE FORM

NAME: _____

DOB: **AGE:** **MALE/FEMALE/OTHER**

COUNTRY OF BIRTH: _____

ETHNICITY: _____

OCCUPATION: _____

ADDRESS: _____

SUBURB: _____

POSTCODE: _____

PHONE: _____

EMAIL: _____

EMERGENCY CONTACT NAME: _____

EMERGENCY CONTACT PHONE: _____

RELATIONSHIP TO YOU: _____

HOME

Do you live with other people/family? If yes, please list below:

_____

_____

_____

TREATING MEDICAL DOCTOR NAME: _____

DO YOU HAVE A REFERRAL? If yes, please bring to first session or email.

ADDRESS OF TREATING DOCTOR:

_____

_____

_____

TREATMENT HISTORY

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

- ☐ no
- ☐ yes (reason for treatment) _____

Have you had previous mental health therapy?

- ☐ no
- ☐ yes (reason for treatment) _____

Are you currently taking prescribed psychiatric medication (antidepressants, antipsychotics, etc)?

- ☐ no
- ☐ yes

If yes, please list:

_____

_____

_____

Prescribed by: _____

CURRENT DIAGNOSES

Have you been diagnosed by a medical professional (psychiatrist or GP)?

- ☐ no
- ☐ yes

If yes, please provide details:

_____

_____

COURT CASES

Do you have any current or pending court cases?

- ☐ no
- ☐ yes

If yes, please provide details:

_____

_____

Do you require a letter from me?

- ☐ no
- ☐ yes

If yes, please provide details:

_____

_____

COURT ORDERS

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

- ☐ no
- ☐ yes

If yes, please provide details:

_____

_____

HEALTH AND SOCIAL INFORMATION

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

_____

Are you currently on medication to manage a physical health concern? If yes, please list:

_____

_____

Are you having any problems with your sleep habits? ☐ no ☐ yes

If yes, check where applicable:

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

☐ Disturbing dreams ☐ Other _____

How many times per week do you exercise? _____

Approximately how long each time? _____

Are you having any difficulty with appetite or eating habits?

If yes, check where applicable: ☐ Eating less ☐ Eating more ☐ Bingeing ☐ Restricting

Have you experienced significant weight change in the last 2 months? ☐ no ☐ yes

Do you regularly use alcohol? ☐ no ☐ yes

In a typical month, how often do you have 4 or more alcoholic drinks in a 24-hour period?

_____

How often do you engage recreational drug use?

☐ daily ☐ weekly ☐ monthly ☐ rarely ☐ never

Do you smoke cigarettes or use other tobacco products?

☐ no ☐ yes

Have you had suicidal thoughts recently?

☐ frequently ☐ sometimes ☐ rarely ☐ never

Have you had suicidal thoughts in the past?

☐ frequently ☐ sometimes ☐ rarely ☐ never

Have you ever experienced any of the following?	
Extreme depressed mood	**No • Yes • Recently**
Dramatic mood swings	**No • Yes • Recently**
Rapid speech	**No • Yes • Recently**
Extreme anxiety	**No • Yes • Recently**
Panic attacks	**No • Yes • Recently**
Phobias	**No • Yes • Recently**
Sleep disturbances	**No • Yes • Recently**
Hallucinations	**No • Yes • Recently**
Unexplained losses of time	**No • Yes • Recently**
Unexplained memory lapses	**No • Yes • Recently**
Alcohol/substance abuse	**No • Yes • Recently**
Frequent body complaints	**No • Yes • Recently**
Eating disorder	**No • Yes • Recently**
Body image problems	**No • Yes • Recently**
Repetitive thoughts (e.g. obsessions)	**No • Yes • Recently**
Repetitive behaviours (e.g. frequent checking, hand washing	**No • Yes • Recently**
Homicidal thoughts	**No • Yes • Recently**
Suicide attempts **If yes, when?**	**No • Yes • Recently**

WHAT ARE YOUR GOALS FOR THERAPY?

_____

_____

_____

_____

TIME AND PUNCTUALITY: A consultation will usually last 60 mins. If you are late, your consultation will usually still finish at the scheduled time, to be fair to your therapist and the clients with appointments after yours.

CONSENT TO SHARING OF INFORMATION

I _____ give permission for Healing Moments

to obtain/exchange appropriate written or verbal information with the following persons/agencies:

Treating Referrer: Psychiatrist ☐ GP ☐ Other ☐ _____

_____

Permission is given until I withdraw my consent:

In writing ☐ 1 year ☐ Other ☐ _____

By signing this form, I declare that the information is true and correct. I acknowledge that I have read, understood, and agree with the Healing Moments (ABN 47 293 802 658) Client Agreement. I understand that the Client Agreement can be found on their website, or I can request a copy from my therapist. I understand I am personally liable for fees associated with this service.

Name: _____ **Signature**: _____

Date: _____