**Counselling Client Intake Form**

Full Name: Click or tap here to enter text. Date: Click or tap to enter a date.

Address: Click or tap here to enter text.

Email Address: Click or tap here to enter text.

Phone Number: Click or tap here to enter text. Date of Birth: Click or tap to enter a date.

What is your age group? [ ]  16 [ ]  17-24 [ ]  25-34 [ ]  35-44 [ ]  45-54 [ ]  55-64 [ ]  65-74 [ ]  Over 75

How would you describe your gender? Choose an item.

Do you identify as Aboriginal and/or Torres Strait Islander person? [ ]  Yes [ ]  No

Would you like to subscribe to our mailing list? [ ]  Yes [ ]  No

What is your preferred contact method? [ ]  Phone [ ]  Email [ ]  WhatsApp [ ]  SMS

Emergency Contact:

Full Name: Click or tap here to enter text. Phone: Click or tap here to enter text.

Counselling for: [ ]  Individual [ ]  Couples [ ]  Families

Describe the reason for which you wish to have counselling:

Click or tap here to enter text.

What would you like to see happen as a result of counselling?

Click or tap here to enter text.

The thing that concerns me most right now is:

Click or tap here to enter text.

How long has this been a problem?

Click or tap here to enter text.

Severity: [ ]  Mild [ ]  Moderate [ ]  Severe [ ]  Overwhelming
In the past month, have you experienced: (Select all that apply)
[ ]  Poor appetite or overeating [ ]  Wild mood swings [ ]  Anxiety

[ ]  Low energy or fatigue [ ]  Rapid speech [ ]  Trauma

[ ]  Low self-esteem [ ]  Fear of gaining weight [ ]  Phobias
[ ]  Poor concentration [ ]  Binge or restrictive eating [ ]  Hallucinations
[ ]  Feelings of hopelessness [ ]  Body image problems [ ]  Sexual abuse

[ ]  Depressed mood [ ]  Panic attacks [ ]  Homicidal thoughts
[ ]  Sleep disturbances [ ]  Repetitive thoughts [ ]  Suicide attempt
[ ]  Diminished happiness [ ]  Excessive worry [ ]  Sexual issues
[ ]  Feelings of worthlessness [ ]  Unexplained losses of time [ ]  Physical abuse
[ ]  Irritability [ ]  Alcohol/substance abuse [ ]  Emotional abuse
[ ]  Feelings of restlessness [ ]  Unexplained memory lapses
[ ]  Muscle tension [ ]  Frequent body complaints

 How good is your physical health at present?

[ ]  Very good [ ]  Good [ ]  Satisfactory [ ]  Unsatisfactory [ ]  Poor
Are you currently under a physician’s care? [ ]  Yes [ ]  No

If yes, for what?

Click or tap here to enter text.
Are you currently receiving psychiatric services, counselling or therapy elsewhere?

[ ]  Yes [ ]  No
Prior outpatient psychotherapy or counselling? [ ]  Yes [ ]  No

If yes, was prior counselling beneficial? [ ]  Yes [ ]  No
Are you currently taking prescribed psychiatric medicine? [ ]  Yes [ ]  No
Medication and dosage:

Click or tap here to enter text.
Do you consume alcohol? [ ]  Yes [ ]  No
If yes: [ ]  Daily [ ]  Weekly [ ]  Monthly [ ]  Rarely
Do you engage in recreational drug use? [ ]  Yes [ ]  No

If yes: [ ]  Daily [ ]  Weekly [ ]  Monthly [ ]  Rarely
Have you had suicidal thoughts recently?

[ ]  Frequently [ ]  Sometimes [ ]  Rarely [ ]  Never

Have you had suicidal thoughts in the past?

[ ]  Frequently [ ]  Sometimes [ ]  Rarely [ ]  Never
Do you have any current or past experiences of sexual abuse or trauma? [ ]  Yes [ ]  No
Do you have any thoughts of hurting yourself or others? [ ]  Yes [ ]  No

Over the last year, have you experienced any significant changes or stressors?

 [ ]  Yes [ ]  No

If yes, please describe:

Click or tap here to enter text.
Childhood family experience: (Select all that apply)

Choose an item.
Social support system: (Select all that apply)
 [ ]  Supportive network [ ]  Few friends [ ]  No friends [ ]  Close extended family
[ ]  Distant from family of origin
Sexual history:
Choose an item.
Employment:
Occupation: Click or tap here to enter text.

[ ]  Employed and satisfied [ ]  Employed but dissatisfied
 [ ]  Unemployed [ ]  Change jobs a lot
Legal history:

[ ]  No legal problems [ ]  Child custody proceedings [ ]  Divorce proceedings
[ ]  Current or pending court case [ ]  Other: Click or tap here to enter text.