**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.