

| Client Information | |
|--|-------------------|
| Client Name: | |
| Birth Date: | |
| Address: | |
| City: | State: |
| Post Code: | Phone Number |
| Email: | |
| Occupational Details | |
| Occupation: | |
| Employer: | |
| Emergency Contact Details | |
| Emergency Contact Name: | |
| Emergency Contact Phone Number: | |
| Emergency Contact Email: | |
| Medical Information | |
| GP's Name: | |
| Contact details: | |
| Psychiatrist Name (if any): | |
| Contact Details: | |
| Symptoms Experienced (Please chec | k all that apply) |
| ☐ Brain fog ☐ Fear/Anxiety ☐ Eating or appetite problems ☐ Family issues ☐ Procrastination ☐ Stress ☐ Self-control/Impulsivity ☐ Self-esteem or confidence | |
| Work/Career/Education concerns Grief/Loss | |









FOR CREATIVE AND DIVERSE MINDS

| Rejection sensitivity/People-pleasing 'Masking' Neglect in childhood Childhood abuse Irritability Insomnia or other sleep issues Physical symptoms (headaches, stomachaches) Mood swings Social withdrawal or isolation Fatigue or lack of energy Feelings of worthlessness or guilt Trouble concentrating or making decisions Restlessness or agitation Persistent sad, anxious, or "empty" mood Difficulty with social interaction Difficulty with communication Restricted interests Repetitive behaviors Hypersensitivity or hyposensitivity to sensory input History of Mental Health Conditions (Family or Personal) Anxiety Depression ADHD Autism Spectrum Disorder (ASD) Eating Disorders/Disordered eating/body image Addiction Bipolar disorder Schizophrenia Post-Traumatic Stress Disorder (PTSD) Obsessive-Compulsive Disorder (BPD) Social anxiety disorder Generalized anxiety disorder (GAD) | | Obsessive/racing thoughts |
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Medication Information:

Are you taking any prescription medication for psychological conditions? If yes, please specify what kind and reason.









Recent Upsetting Events

Have you gone through any upsetting events recently? (Please specify)

Stress/Anxiety Source

Please comment on the most current significant source(s) of Stress/Anxiety.

Additional Information

Is there any other information that would be helpful for us to know about?

Safety Considerations

At times everyone feels down or upset. However, when someone feels very low, they may think about harming themselves or suicide. Have you had any thoughts of harming yourself or suicide?

If yes, it is important that we discuss this further during our first session. Please book in for 90 minutes if possible so we have time to do a risk assessment without compromising on understanding the mechanisms behind this.











Coping Mechanisms

Who do you turn to for support?

Strengths/Goals

What are some of your strengths, hobbies, interests?

What are your goals, or, what would you like to achieve out of our sessions together?

Have you sought support before? If so, what did you find helpful or unhelpful.

Please elaborate on what has been helpful/unhelpful.

Additional Information

Anything else you think we should know about you so I can provide you with the best support possible.

Confidentiality Statement

All information you share on this form will be held in strict confidence, subject to legal requirements. I adhere to the Privacy Act 1988 and the Australian Privacy Principles (APPs) to protect your personal and sensitive information. I use this information solely for the purpose of providing you with the best possible care and support. Your information will not be shared with any third parties without your express consent unless there is a serious threat to your life or health or as required by law.

Client Signature

Client Name:

Date:





