**CLIENT INTAKE FORM**

Welcome to **Parkway Counselling**.

In order for us to prepare for your session, please complete the following form. If you have any questions or are unsure what to write, please let your therapist know.

**About You**

First Name: Last Name:

Date of Birth: Date of First Appointment:

Home Phone: Mobile:

Email:

Address:

Emergency Contact Name:

Emergency Contact Phone:

Private Health Cover Options

**Payment Information**

Payment is required on the day of the appointment unless otherwise arranged and can be made by credit card,

EFTPOS, via Halaxy booking system or bank transfer.

**Referral Details**

Do you have an NDIS referral? Y N

If yes, do you have a copy of your NDIS plan? Y N

If yes, who is your Support Coordinator?

Were you referred through your Employer? EAP? Y N

Who is your employer?

**Claiming Details**

Your NDIS Number:

Your EAP Number:

Private Health Cover Options:

**Health History**

Diagnosis (if any)

Date of Diagnosis

Reason for seeking counselling (check all that apply)

Anxiety Depression Trauma Low self-esteem Grief and Loss Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Presenting Issues**

Please briefly describe the reason for your visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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How long has this been a problem?

What has been the most challenging concern in the past 3 months?

What have you already tried to fix it / reduce it / improve it?

**Cancellation Policy**

Thank you for respecting our time as we respect yours. Our cancellation policy states that your credit card will be charged **$50.00** of the session fee for cancellations made within **24**  **HOURS** prior to the session. If cancelled within 24 hours of the session, you will be charged **$50** of the session fee.

**Registration**

I am a registered counsellor with the Australian Counselling Association (ACA) membership number 19890. I am bound by their Code of Practice. Please visit their website if you would like to clarify ethical standards and counselling practice [www.theaca.net.au](http://www.theaca.net.au)

As a social worker I also adhere to the Code of Practice of the Australian Association of Social Work (AASW). Please visit their website if you would like further information [www.aasw.net.au](http://www.aasw.net.au)

**Confidentiality**

It is my goal to up-hold the strictest ethical standards of confidentiality. I will not pass information on to any other person. However, if someone is at risk of harm to themselves or others, I am legally bound to break confidentiality and enact Duty of Care to assist in maintaining everyone’s safety.

**Supervision**

I attend regular supervision which is part of the Code of Practice for counsellors and social workers. I discuss cases of counselling with my supervisor, in order to gain the best outcomes for clients and for me to gain greater understanding in my practice. During supervision your identity remains hidden.

**If you are participating in Walk and Talk Therapy in the outdoors, please note that it is at your own risk and it is your responsibility to wear appropriate footwear, be able to participate in outdoor therapy, be mobile enough to participate, use sunscreen, wear a hat.**

I have read and understand the above information. I understand the risks and benefits of counselling, the nature and limits of confidentiality, and what is expected of me as a client of the Counselling Services.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have read and understood this Intake Form and agree to the above conditions and terms of service.

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If client is under 18 years of age:**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, provide consent for the exchange of verbal and written correspondence

about my child’s service at **Parkway Counselling** be provided to:

Parent/Guardian’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thank you for choosing **Parkway Counselling** to support you in your journey. If you have any questions, please do not hesitate to **CALL US ON 0423 151 852 OR SPEAK WITH YOUR PRACTITIONER.**