MINDFUL CARE
COUNSELLING

NEW CLIENT INTAKE FORM

Client Information

Full Name: _____

Date of Birth: _____

Pronouns (optional): _____

Address: _____

_____

Phone Number: _____

Email Address: _____

Preferred Contact Method: Phone / Email / SMS

Emergency Contact

Name: _____

Phone Number: _____

Relationship to Client: _____

GP Details (optional)

GP Name / Clinic: _____

Phone Number: _____

Reason for Attending Counselling

Please briefly describe what brings you to counselling:

_____

_____

_____

Current Concerns

Please tick any that apply:

[ ] Anxiety

[ ] Depression or low mood

[ ] Stress

[ ] Relationship issues

[ ] Trauma

[ ] Grief/loss

[ ] Family conflict

[ ] Work/school issues

[ ] Emotional regulation

[ ] Self-esteem

[ ] Behavioural concerns

[ ] Other: _____

Medical / Mental Health History

Do you have any diagnosed conditions?

[ ] No [ ] Yes – list:

_____

Are you currently taking any medications?

[ ] No [ ] Yes – list:

_____

Have you received counselling before?

[ ] No [ ] Yes – describe:

_____

Risk & Safety

Are you experiencing thoughts of self-harm/suicidal thoughts?

[ ] No [ ] Yes – details:

_____

Do you feel safe at home?

[ ] Yes [ ] No [ ] Unsure

NDIS (if applicable)

Are you an NDIS participant?

[ ] No

[ ] Yes – Plan Managed

[ ] Yes – Self Managed

[ ] Yes – Agency Managed

NDIS Number: _____

Support Coordinator (if applicable):

Name: _____

Phone: _____

Email: _____

Consent to Treatment

Please read and tick:

[ ] I understand confidentiality and its limits.

[ ] I agree to participate voluntarily.

[ ] I consent to collection of personal information.

Signature: _____ Date: _____