A: 146 Raleigh Street, Thornbury VIC 3071
P: (03) 94168974 **H** 9am - 5pm
W: www.ikigaiseeds.com - admin@ikigaiseeds.com

Registration Form (Adult)

To complete this form digitally without Adobe Acrobat, download file, open and fill in, select PRINT and change the printer to SAVE AS PDF. Once completed, please send to admin@ikigaiseeds.com with any relevant supporting documents if necessary.

Client's Details

First name: Surname: Preferred name:
DOB: Gender: Pronoms:

Occupation: Higher education completed:
Home Address:
Phone: Mobile:
Email:

Emergency Contact or Guardian*:
Relationship to patient:
Phone: Mobile:

Person completing this form and relationship to client:

Referrer Details

Name: Clinic:
Phone: Email:

Client's History

Does the client have a formal diagnosis? ▢ YES | ▢ NO
If yes, please explain:

Has the client seen a mental health professional in the past? ▢ YES | ▢ NO
If so, name of the previous practitioner:
Clinic: Phone: Email:

Does the client have any family history of mental illness/disability: ▢ YES | ▢ NO
If yes, please explain:

Has the client ever experienced any trauma or phobia? ▢ YES | ▢ NO
If yes, please specify:

Does the client have any allergies*, anaphylaxis*, asthma* or seizures*? ▢ YES | ▢ NO
If yes, please specify:

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Does the client have any medical condition*? ▢ YES | ▢ NO
If yes, please specify condition/s and since when:

Does the client take any medication*? ▢ YES | ▢ NO
If yes, please specify since when, type of medication, quantity, frequency and reason for prescription:

**Please note that if the client suffers any allergy, asthma, anaphylaxis, seizures or other medical condition that require urgent treatment you must bring the corresponding medication/treatment with you to each therapy session.*

Does the client drink alcohol? ▢ YES | ▢ NO | ▢ PAST
Does the client smoke? ▢ YES | ▢ NO | ▢ PAST
Does the client use any recreational drugs? ▢ YES | ▢ NO | ▢ PAST
Does the client suffer from any addiction/s? ▢ YES | ▢ NO | ▢ PAST

On a scale of 1 –10 how would you rate the level of violence and conflict in the client's family or household? *Rating Scale: 1-4 = Mild | 5-8= Moderate | 9-10 = Extreme*

Major Concerns

Please tick (✓) all that apply to the client and explain below:
□ Learning difficulties
□ Academic performance
□ Gross motor
□ Fine Motor
□ Visual perceptual
□ Sensory issues
□ Cognitive Functioning
□ Emotions/ Feelings/ Mood
□ Self-Esteem/ Confidence
□ Self-regulation
□ Play/Joy difficulties
□ Gender/Identity
□ Workplace Bullying
□ Behaviour
□ Speech/Language/Communication
□ Dressing
□ Toileting
□ Eating/ Eating Disorders
□ Friendships / Social Skills / Emotional Intelligence
□ Relationships / Sexuality / Couples / Marriage challenges

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□ Anxiety / phobias
□ Depression / grief / loss
□ Family Issues
□ Violence
□ Trauma
□ Addictive behaviours
□ Other (please, specify)

Detailed Reason for Referral

Therapy Type:

☐ Psychology | ☐ Counselling | ☐ Art Therapy | ☐ Psychotherapy/Gestalt

☐ Group Therapy | ☐ Mediation | ☐ Family Therapy | ☐ Social Skills / Friendship Group

☐ Speech Therapy | ☐ Occupational Therapy | ☐ Social Worker | ☐ Support Worker

☐ Unsure of which service best suits the client's situation

Funding:

☐ Private Health (please specify which one):

☐ Mental Health Care Plan | ☐ Enhanced Primary Care Plan

☐ NDIS (Self Managed*) | ☐ NDIS (NDIA Managed**) | ☐ NDIS (Plan Managed*) |

☐ Other (please specify):

☐ None

**Please note, we only provide services to NDIS self-managed and plan managed and we require a copy of the client's NDIS plan with this registration form.*
***Please note, we don't provide services to NDIA managed clients*

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PREFERRED APPOINTMENT TIME: please tick (✓) all that apply

DAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
MORNING 8.30AM-12PM						
AFTERNOON 12-3PM						
AFTER SCHOOL 3-9PM						

Please note: afterschool and Saturday appointments are limited and may result in a longer wait period if this is client's only availability

INFORMED CONSENT, CONFIDENTIALITY & RELEASE OF INFORMATION:

Please read the following statements regarding treatment, and sign to acknowledge you agree to these terms:

- As part of providing a service to you, we collect and record personal information from you that is relevant to your current situation. This information will be a necessary part of the assessment and treatment that is conducted.
- All personal information gathered by Ikigai seeds during intake, assessment and/or therapy remains confidential and secure except in the following circumstances:
    - It is subpoenaed by a court
    - The therapist becomes aware of any risk to yourself or others
    - You agree to, and sign consent allowing material to be retrieved/forwarded to a third party, such as a GP or other clinician for treatment/management purposes
- Routine practice requires written and at times verbal communication with your referring doctor (if applicable) and supervising clinicians within Ikigai seeds.
- If you are referred under a Mental Health Care Plan through Medicare written communication with your referring GP is mandatory after an initial six Medicare rebated sessions and any other subsequent sessions.
- Applicable fees are to be paid at each session unless otherwise negotiated with your treating therapist.
- <u>In cases where parents/guardians of a child are separated and there is a shared care arrangement or no formal custody arrangements, both carers must consent to the child undergoing treatment or therapy services at Ikigai seeds by signing this form</u>
- This form must be signed at intake in order for treatment or services to proceed. The patient cannot receive treatment or services unless this form has been completed
- So that therapists' time is utilised effectively, a cancellation fee to the value of 100% of the session fee applies if the client does not attend their appointment, or gives less than 24 hours notice of non-attendance. For NDIS clients a cancellation fee to the value of 100% of the session fee applies if the client does not attend their appointment, or gives less than 48 hours notice of non-attendance.

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Please list any Specialist (past or current) GP, Specialist, Occupational, Physical or Speech Therapist, Neurologist, Psychologist, Psychiatrist, Teacher etc that you would like your Ikigai seeds therapist to communicate with:

Name: Occupation:
Address/Clinic:
Phone:
Email:

Name: Occupation:
Address/Clinic:
Phone:
Email:

Name: Occupation:
Address/Clinic:
Phone:
Email:

Name: Occupation:
Address/Clinic:
Phone:
Email:

Please tick: ☐ I consent to my therapist communicating within the Ikigai seeds Therapy team

I/we have read the above informed consent, confidentiality, release of information and cancellation policies and give consent to the parties listed above to release and request information related to my/my child's history and treatment. I understand that this permission can be revoked at any time by myself in writing except for the information that has already been communicated. I am aware that cancellation fees are unable to be paid for by Medicare. I/we agree to the above conditions and to my self/child receiving clinical services at Ikigai seeds Child, Adolescent, Adult, Family and Group Therapy Services.

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To be completed by client (if 18 or older) or both parents/guardians (if client is under 18 or incapacitated to sign):

Full Name	Full Name
Address	Address
Phone Number	Phone Number
Signature Date	Signature Date

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