CLIENT INFORMATION FORM

PERSONAL DETAILS

Title: _____

Client First Name: _____Client Last Name: _____

Sex: Male / Female / other _____ Date of Birth: _____

Address: _____

_____Postcode: _____

Home Phone Number: _____ Mobile Number: _____

Email Address: _____

Relationship status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Other: _____

Do you have any children? ☐ Yes / ☐ No (If yes how many?) _____

Are you pregnant? ☐ Yes / ☐ No (If yes how many months/weeks?) _____

Current Living Arrangements: _____

Private Health Fund: _____

Private Health Fund Number: _____

MEDICAL CONCERNS & RISK ASSESSMENT

Medical History / Conditions: (Diabetes, Allergies, Heart Attack, Asthma, etc.)

_____

_____

Current Medications:

_____

_____

History of mental health issues in your family: ☐ Yes / ☐ No

(If yes, please specify) _____

_____

History of substance use / addiction concerns in your family: ☐ Yes / ☐ No

(If yes, please specify) _____

_____

Have you ever had any previous counselling? ☐ Yes / ☐ No

(If yes, please specify e.g. when/where?) _____

_____

If applicable – was your previous counselling experience successful? ☐ Yes / ☐ No
(Please explain) _____

_____

Have you been professionally diagnosed with any mental health condition? ☐ Yes / ☐ No
(If yes, please specify) _____

_____

Have you ever been hospitalised for mental health? ☐ Yes / ☐ No
(If yes, please specify) _____

_____

Have you ever been treated for substance use or any other addictions? ☐ Yes / ☐ No
(If yes, please specify) _____

_____

Any previous attempt at self-harm: ☐ Yes / ☐ No (If yes please explain) _____

Any previous attempts of suicide: ☐ Yes / ☐ No (If yes please explain) _____

Any current plans of suicide: ☐ Yes / ☐ No (If yes please explain) _____

Are you currently experiencing any of the following, at risk situations (Please tick)?

☐Homelessness ☐Living in a refuge ☐ AVO's or warrants ☐Domestic violence ☐In an unsafe situation

☐Parole or good behaviour ☐Other_____

_____

EMERGENCY CONTACT

First Name: _____ Last Name: _____

Relation: _____ Contact Number: _____

Address: _____

_____ Postcode: _____

Email Address: _____

OTHER

Goals for therapy: _____

_____

_____

Preferences / Availability for Appointment Times: _____

Counselling Method Preferences (Please Circle Preference Below)

In Person Mobile Zoom Telephone

How did you find out about Better You, Today? _____

Client Name: _____

Client Signature: _____ Date: _____

Counsellor Name: _____

Counsellor Signature: _____ Date: _____