

1. Participant Details

Participant Name		D.O.B	/	/	Pronoun	
Preferred Name						
NDIS Number						
Contact details	Home		Mobile			
Email address						
Language spoken at home:				Interpreter required	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Preferred option for communication	<input type="checkbox"/> Email	<input type="checkbox"/> Post	Do you identify as Aboriginal and Torres Strait Islander?			
	<input type="checkbox"/> Phone		<input type="checkbox"/> Yes <input type="checkbox"/> No			
Residential Address:						
Postal Address (If different from above)						

Is there a Guardianship and/or Administration order in place? Yes No

Is there a Behaviour Management Plan in place? Yes No

Participants under the age of 18, under guardianship or in the care of family or caregivers, please complete below

Name of Parent/Guardian 1	Primary Carer		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Lives with Participant		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Emergency Contact		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Relationship to participant	<input type="checkbox"/> Parent	<input type="checkbox"/> Guardian	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Other
Residential Address:				
Postal Address (if different from above)				
Contact details	Home		Mobile	
Email address				

Name of Parent/Guardian 2	Primary Carer		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Lives with Participant		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Emergency Contact		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Relationship to participant	<input type="checkbox"/> Parent	<input type="checkbox"/> Guardian	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Other
Residential Address:				
Postal Address (if different from above)				
Contact details	Home		Mobile	



Email address	
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2. Please provide information about conditions that may impact your outdoor session. Disability / Medical Conditions including any diagnosis if relevant.

1.	
2.	
3.	

Behaviour Support Plan documents collected for authorisation purposes (if relevant) Yes No

Behaviour Support Plan available on NDIS portal? Yes No

Other service providers currently using (include Specialist Behaviour Support Provider, if relevant)

Name	
Address	
Phone number/email	
Frequency of use:	

Name	
Address	
Phone number/email	
Frequency of use:	

Name	
Address	
Phone number/email	
Frequency of use:	

3. Health Care Information

Medicare Number		Expiry Date:	
Private Healthcare Provider		Reference Number:	
		Membership Number	

Reference Number	
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Doctor Name	
Address	
Phone Number	

4. Funding

NDIS Managed (A copy of the NDIS plan MUST BE provided for NDIA managed participants)

NDIS Number:	
NDIS Date:	

Self-Managed Plan Managed

Please provide details for invoices

Name	
Email	
Comments	

5. Preferences

Preferred name	
Religious Requirements	
Cultural Requirements	
Communication device	
Physical Assistance	
Other Considerations	

6. Goals and Aspirations

What do you want to achieve for yourself – life skills, physically, socially etc?	
Immediately	
In 6 months	
Next year	

7. Risk Assessment

Risk Assessment Tool	Strategies Developed	Identified in Support Plan
Individual risk profile	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No



Safety Environment Checklist – Home	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Sa Reay Counselling specialise in Outdoor Therapy and would like to know your reason/s for accessing our services. Please mark any/all applicable to you.

- I find it too confronting to sit across from someone in an office setting
- I love the idea of movement and being outside during a session
- I have tried office-based therapy and it just wasn't for me
- I can't keep still and don't like to remain seated for long
- I get anxious / nervous /overwhelmed in an office
- I want to deal with a fear in the outdoors such as fear of crowds, social anxiety, spiders etc.
- I need support to go for a walk and/or to be around others
- Other

Please mark what best describes your reason for seeing a therapist.

- I want to be more confident
- I want to feel better
- I want to stop a habit
- I want to improve my self-esteem I want to improve my mood
- I have lost someone I love
- I want to deal with my past
- I want to improve my focus
- I need to stress less
- I want to improve my relationships/s
- I want to slow down my thoughts
- I would like help with a life transition
- I would like help with a decision I need to make I would like help processing a situation
- Other

Please answer the following questions

	YES	NO	UNSURE	RATHER NOT SAY
Have you previously seen a counsellor, psychologist, or therapist?				
Are you involved in any court proceedings, or do you require a legal report?				
Do you use drugs or do you drink alcohol to excess?				
Have you ever experienced any form of domestic violence?				
Have you been convicted of any crimes involving violence?				
Is there any previous mental health hospitalisation or issues that we should be aware of?				



If you answered "Yes" to any of the above questions, can you add any additional information here?

Are there any considerations Sa Reay Counselling need to know in relation to your culture, gender, living arrangements or privacy, linguistic diversity, disabilities or accessibility. Any information Sa Reay Counselling need to know to ensure the service provided is tailored to your needs? If you answer "Yes" to this question, please add information below.

I understand that:

- This organisation owns these records.
- I can ask to see records and receive a copy
- Records are archived for a set period according to policy and procedure
- I understand that all information obtained will be kept confidential.

To the best of my knowledge, the information provided in this form is true and correct:

Participant Signature or	
Parent / caregiver signature	
Name of the person signing	
Relationship to the participant, if not the participant	
Date	

Note: Authority to Act as an Advocate form is required if the individual signing this form is not the participant.