

Client Intake Form.

If you prefer, we can discuss any of the information in this form in person.

Please see our **Privacy and Confidentiality Agreement** for details about how your information will be protected.



Referred by (if applicable)	Date
	DD / MM / YYYY

Personal Details

First Name	Surname	D.O.B
		DD / MM / YYYY
Address	Suburb	
State	Postcode	Email (only include if it is OK to email)
Preferred Phone Number	Ok to identify caller? <input type="checkbox"/> Yes <input type="checkbox"/> No	Ok to leave messages? <input type="checkbox"/> Yes <input type="checkbox"/> No
First Language	Ethnic/Cultural Identity	
Preferred Pronouns	<input type="checkbox"/> she/her/hers <input type="checkbox"/> he/him/his <input type="checkbox"/> they/their <input type="checkbox"/> Other (please specify)	

Relationship Status

Select One	
<input type="checkbox"/> Single <input type="checkbox"/> Dating <input type="checkbox"/> Living with partner <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
Spouse Name	Spouse Gender Pronouns
Other Significant Relationships (parents, children, siblings, etc.)	

Emergency Contact

Name	Contact Phone Number
Alternative Contact Number	Permission to contact in case of emergency? <input type="checkbox"/> Yes <input type="checkbox"/> No
Relationship to You	

Health & Medical Details

GP Name	GP Practice
Medication (if relevant)	
Diagnosed/Suspected Health Conditions (including Mental Health)	
Previous Experience of Counselling/Psychotherapy	

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Other Information

Reason for seeking counselling
Anything else you would like me to know about you or which might be important for me to know?
How did you hear about this counselling service?