CLIENT INFORMATION

DATE____/_____/_____

Identification Information

Name_____

DOB_____/_____/_____

Address_____

Home Phone_____

City_____

State_____ Post Code_____

Work Phone_____ Mobile Phone_____ Email:_____

Can we leave a message on your: Work ☐ Home ☐ SMS ☐ Email ☐

Employer/School_____

Occupation/Studying_____

Referral Information

Who referred you to me?_____ Medical Practitioner ☐ Other ☐

May I have your permission to contact them (if health practioner Yes ☐ No ☐

Medical/Biological Information

Major or chronic illnesses/injuries:

_____

_____

Medications:

Current Medications:	
Dosage:	
Frequency:	
Prescribing Physician:	

Family Information

Relationship Status: *(Please tick)*

Single	☐
Married	☐
Partner	☐

Divorced	☐
Widow/Widower	☐

This is my: *(Please tick)*

1st		2nd		3rd		4th		Marriage/Partnership

Number of children/step-children and their ages:_____

_____

_____

Were your parents: *(Please tick)*

Divorced	☐
Never Married	☐
Still Married	☐
Widowed	☐

Family history of: *(Please tick)*

Depression	☐
Suicide Attempts	☐
Anxiety	☐
Eating Disorders	☐
Mental Illness	☐
Violence	☐
Sexual Abuse	☐
Emotional Abuse	☐
Alcoholism/ Drug Addiction	☐
Chronic Illness	☐

_____

Treatment Information

Please describe the main concerns that prompted you to seek services at this time:

_____

_____

_____

How have these concerns evolved over time?

_____

_____

_____

Please indicate what major stressors you have had in the last twelve months? *(Please tick)*

Serious illness or injury	☐
Death of a close friend or family member	☐
Major illness in family	☐
Gain of new family member	☐
Divorce/separation/relationship ending	☐
Job change	☐
Other:	☐

What would you like to be different in your life when you are done with Therapy?

_____

_____

_____

Have you ever received psychological services or counselling before? Yes ☐ No ☐

If so, please describe when, from whom, purpose and the results:

_____

_____

_____

Have you ever been prescribed medication for psychiatric or emotional problems? Yes ☐ No ☐

If so, please describe when, prescribing Clinician, what medication, for what and the results:

_____

_____

_____

Have you ever been hospitalised for a psychiatric or emotional reason? Yes ☐ No ☐

If so, please describe, when, where, for what reason and the results:

_____

_____

_____

Have you been in a drug or alcohol program? Yes ☐ No ☐

If yes, how many times?_____

If so, when, inpatient or outpatient, how long and outcome:

_____

_____

_____

Please check any of the symptoms/problems below that apply:

Eating/appetite	☐
Excessive concerns about weight	☐
Difficulty with sleeping (falling asleep/staying asleep/waking up)	☐
Loss of interest in activities	☐
Thinking about one topic excessively	☐
Doing one activity over and over	☐
Thinking about a traumatic event where you or a loved one could have been killed or seriously harmed	☐
Loss of energy/frequent fatigue	☐
Difficulty with fear/phobias/thoughts of death/dying	☐
Unusual thoughts or behaviour ticks or recurrent involuntary movements	☐
Seeing or hearing things that others cannot see or hear	☐
Excessive social awkwardness or difficulty finding/keeping friends	☐
Feeling easily irritated	☐
Excessive conflicts with family	☐
Excessive suspiciousness and fear	☐
Excessive conflicts with friends	☐
Trouble with gambling	☐
Need to be perfect/being a perfectionist	☐
Trouble with sexual behaviours	☐
Difficulty with gender/sexual orientation	☐
Problems with the legal system/the Law	☐
Difficulties being alone	☐
Excessive/impulsive spending	☐
Substance abuse	☐

Frequently being anxious/tearful	☐
Caffeine usage	☐
Panic attacks	☐
“Cigarettes”	☐
Anxiety with public speaking	☐
Alcohol use	☐
Easily distracted from tasks	☐
Difficulty with sustained attention	☐
Recreational drug use	☐
Physical, sexual or emotional abuse	☐
Harming self	☐
Violent behaviours or thoughts towards others	☐
Mental illness of a family member	☐
Suicidal thoughts or behaviours	☐
Witnessing or being involved with a domestic violence situation	☐

Have you ever attempted or are you contemplating suicide? Yes ☐ No ☐

If yes, please provide details:

_____

_____

_____

Do you have a history of hurting yourself, for example, through cutting or burning? Yes ☐ No ☐

If so, please describe:

_____

_____

CONFIDENTILATY AND PRIVACY: Therapy and Counselling is confidential, with the below stated exceptions.

<u>Duty to Warn</u>: Therapists are mandated by law to disclose pertinent information discussed in therapy if the client has an intent or plan to harm another person. We are required to inform the intended victim and notify legal authorities.

<u>Suicide/Self harm</u>: Depression is common emotion expressed in therapy, but if a client is feeling hopeless enough to imply or disclose a plan for suicide; steps need to be taken to ensure safety.

This would include notifying the legal authorities as well as make reasonable attempts to notify the family. Please see full privacy policy on website- alindasmall.com

Subpoenaed Records Fee Notice:
In the event that client records, case notes, or related documentation are subpoenaed or otherwise requested for legal proceedings, a processing fee of **$700** will be incurred. This fee covers the time and administrative effort required to review, prepare, and produce such materials in accordance with applicable legal standards. The fee applies per subpoena and must be paid prior to the release of any records.

<u>CLIENT PAYMENT INFORMATION: Session Fee and Cancellation</u>: Sessions are for 50 minutes duration and the fee is due at the time of consultation. In the event of cancellation 24 HOURS NOTICE must be given, otherwise the FULL SESSION FEE will be charged to the clients' credit card, which is kept on file.

I have read and understand the above-stated limitations to confidentiality and cancellation charges. I accept the subsequent ramifications should there be a need to act on one of the above- stated exceptions. Other than the noted exceptions, if there are reasons to disclose my protected confidential information I understand that I will be provided a Release of Information form.

Client Signature: _____Date:_____

CREDIT CARD NUMBER……

CREDIT CARD NAME……..

EXPIRY DATE…… CCV……..

If you are currently thinking about harming or killing yourself, please call 000 if a life is in danger and let your Clinician know immediately so that the timing of your appointment can be adjusted to address such issues. Please also discuss with a general medical practitioner as they often have names/numbers of services appropriate to urgent matters.

Other

Is there anything else you think I should know about prior to us meeting?

_____

_____

_____

_____

_____

Thank you for your time in completing this form. I look forward to meeting and discussing treatment options with you. Once again, if there is an urgent concern that needs to be addressed, please contact an appropriate local, state, or national service as well as your Clinician for options. A general medical practitioner is often able to provide the names/numbers of needed contacts in the case of urgency.

If a life is in danger, please contact 000 immediately.