**CLIENT INTAKE FORM**

**PERSONAL INFORMATION**

|  |
| --- |
| Full Name: |
| Parent/Legal Guardian (if under 18): |
| Date of Birth: | **Identifies As:** |
| Home Phone: | **Mobile Number:** |
| Address: |
| Email Address: |

**MEDICAL INFORMATION**

|  |
| --- |
| General Practitioner: |
| Practice Name: | **Phone:** |
| Other Health Practitioners/s:  |
| Medication(s): |
| Medicare Card No: | **Ref No:** | **Expiry:** |

**DETAILS FOR APPOINTMENTS**

|  |
| --- |
| Reason for Referral: |
| Current Concerns:

|  |  |
| --- | --- |
| Depression |  |
| Anxiety |  |
| Anger |  |
| Confidence/Self-Esteem |  |
| Eating Disorders |  |
| Health Concerns |  |
| Post Traumatic Stress Disorder |  |
| Alcohol/Substance use |  |
| Relationships |  |
| Trauma |  |
| Behaviours and Habits |  |
| ADHD |  |
| Autsism |  |
| Other (Please note) |  |

 |
| Day/Time Preferences:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Monday | Tuesday | Wednesday | Thursday |
| Morning |  |  |  |  |
| Afternoon |  |  |  |  |
| Evening |  |  |  |  |

 |
| Please mark current therapies that you are interested in:

|  |  |
| --- | --- |
| Psychology/Counselling |  |
| Social Support  |  |
| Mentoring |  |
| Youth Support |  |
| Behaviour Support |  |
| Life Skills |  |
| Other (Please Note) |  |

 |
| Anything else we should know? |

**PARTICIPANT / GUARDIAN DECLARATION**

*I consent to my information being provided to Elevated Psychology and Supports for the purposes of referral, service delivery and inclusion in de-identified data reporting.*

Name:

Date:

Signature: