**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: