CLIENT INFORMATION & CONSENT FORM

Identification & Contact Information

Name_____

DOB_____/_____/_____

Address_____

City_____

State_____ Post Code_____

Email:_____

Mobile Phone_____

Home Phone _____

Work Phone_____

Preferred Method of Contact

Mobile Home SMS Email

Employer/Education Provider _____

Occupation/
Studying_____

Referral Information

Who referred you to me? _____	Medical Practitioner	Other
May I have your permission to communicate with the health care provider?	Yes	No

Medical/Biological Information

Do you have any chronic illnesses or major injuries? If so please specify:

_____

_____

_____

_____

Are you taking any medications? If so please specify:

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:_____

_____

_____

_____

Are your parents: *(Please tick)*

Divorced
Never Married

Still Married
Widowed

Do you have a family history of: *(Please tick all that apply)*

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 therapy 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 all that apply)*

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: *(Please Specify Below)*

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 yes, please describe when, from whom, purpose and the results:

_____
___

_____
___

_____
___

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

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

_____
___

_____
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_____
___

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

If yes, please describe how many times, when, inpatient or outpatient, how long and outcome.

_____
___

_____
___

_____
___

Have you experienced any of symptoms/problems below *(tick all 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 yes, please describe:

_____
___

_____
___

_____
___

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

_____
___

_____
___

_____
___

Privacy and Limits of Confidentiality

Therapy and Counselling is confidential, with the below stated exceptions.

Duty to Warn: 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.

Suicide/Self harm: 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 may include notifying the authorities as well as making reasonable attempts to notify your family.

Required Legal Disclosure: In addition to the above we may be required by law to disclose pertinent information if required to do so during the handling of a complaint or legal action.

Where practically possible, if there are reasons to disclose confidential information, I will attempt contact you directly to notify you of the said disclosure requirement.

As a provider of relationship counselling and sex therapy services we are bound by the legal requirements of the Australian Privacy Principles set out in the Privacy Act 1988 (Cth), in so far as we deal with your personal information. A copy of our Privacy Policy is available on our website at www.alindasmall.com.

Should you have any concerns about privacy and limits of confidentiality please contact Alinda Small using the contact details on our website.

Terms & Conditions

1. ***Sessions are for 50 minutes duration***

2. ***The session fee is due at the time of consultation.***

3. ***In the event of cancellation 24 HOURS NOTICE must be given, either by text or email, otherwise the FULL SESSION FEE will be charged to your credit card.***

CREDIT CARD NUMBER……

CREDIT CARD NAME……

EXPIRY DATE…… CCV……

Your Acknowledgement

1. ***The information I have provided in this form is accurate to the best of my knowledge and belief.***
2. ***I have read and understand the above-stated limitations to confidentiality and cancellation charges***

Client Signature: _____Date:_____

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.