**CLIENT REGISTRATION FORM**

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| **PERSONAL CONTACT DETAILS** |
| **First Name:** | **Surname:** |
| **Preferred name:** | **Date of birth:** |
| **Address:** |
| **Suburb:** | **Postcode:** |
| **Email:** |
| **Phone** | **Mobile:** | **Home:** |
| **EMERGENCY CONTACT DETAILS** |
| **Name:** | **Phone:** |
| **Relationship to you:** |

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| **MEDICARE**  |
| **Medicare number:** |
| **Number on card:** | **Expiry:** |
| **GP DETAILS (if accessing through medicare)** |
| **GP Name:** | **Contact number:** |
| **GP clinic address:** |
| **Date of referral:** | **Have you used any sessions with a different psychologist in the current calendar year? Y N****If so, how many: \_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

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| **INTAKE INFORMATION** |
| **Please provide a brief summary of the reason for your referral or select any presenting issues that apply to you:**AngerSelf esteemAntenatal/Post Natal issuesGrief and lossTraumaSubstance use/ AddictionsHealth issuesLife transitions/adjustment issuesDepressionAnxietyStressRelationship issues |
| **Have you seen a psychologist or counsellor in the past? If so, when?** |  **Y N** |
| **Please specify your living situation:**  |
| **Marital status:** |  |
| **Who do you live with?** |  |
| **Do you have any children? If so, how old are they?** |  |
| **Are you currently employed?** **If so, on what basis? (Casual/PT/FT)** |  |

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| **This section is only applicable for couples counselling:**If you are seeking couples counselling, please provide the contact details for your partner: |
| **Partner’s name:** | **Partner’s DOB:** |
| **Partner’s contact number:** | **Partner’s email:** |

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| **APPOINTMENT PREFERENCES** |
| **Please select your preferable days and times for appointments:**MorningAfternoonEveningThursdayFridaySaturdayMondayTuesdayWednesday  |
| **Preferred psychologist :****(if you have been recommended to see someone in particular or have a preference based on our website)** |  |