STICKS & STONES
THERAPEUTIC SERVICES

Individual Counselling

Client Intake Form

Intake Date:

The provided information is entirely at your discretion.
The purpose of this information is to assist in service planning.

Personal Information

First Name: Surname:

Date of Birth: Age: Gender:

Preferred Name:

Marital Status:

- ☐ Never Married
- ☐ Divorced
- ☐ Separated
- ☐ Married
- ☐ Domestic Partnership
- ☐ Widowed

Please tick ALL boxes that apply to

- ☐ Aboriginal/Torres Strait Islander
- ☐ Person with a disability
- ☐ From Isolated/Rural area
- ☐ LGBTIQ+
- ☐ Non-English speaking background

- these are Equity Charters which help with the evaluation of ourservice delivery

Contact Information

Phone: May we leave a message? ☑ Yes ☐ No

Email: May we leave a message? ☑ Yes ☐ No

Other Phone: May we leave a message? ☑ Yes ☐ No

- Please note: Email correspondence is not considered to be a confidential medium of communication.

Street Address:

Suburb: Post Code:

Is This: ☐ Residential ☐ Postal ☐ Both

Emergency Contact

First Name: Surname:

Phone: Email:

Relationship:

- *Please not: By providing this information you are giving consent to Sticks n' Stones Therapeutic Services to make contact with this person in the event of no contact with you and/or in an emergency*

Referral

Referred by: Referral Date:

Referrers Name: Referrers Practice:

Provider Number: Referrers Practice:

Referrers Contact: # of Sessions: Review Date:

Referral Type:

Other Info:

Parent/Guardian (If under 18)

Parent/Guardian 1

First Name:

Surname:

Phone:

Email:

Relationship:

Parent/Guardian 2

First Name:

Surname:

Phone:

Email:

Relationship:

Who can we contact: ☐ 1 ☐ 2 ☐ Both

History

1. Have you previously received any type of mental health services (E.g. psychotherapy, psychiatric services) ?

☐ Yes ☐ No

Previous Practitioner:

2. Are you currently taking any prescription medication?

☐ Yes ☐ No

3. Have you ever been prescribed psychiatric medication?

Please list:

☐ Yes ☐ No

Please list:

General & Mental Health Information

1. How would you rate your current physical health?

○ Poor ○ Unsatisfactory ○ Satisfactory ○ Good ○ Very Good

List any specific health problems you are experiencing

2. How would you rate your current sleeping habits?

○ Poor ○ Unsatisfactory ○ Satisfactory ○ Good ○ Very Good

List any specific sleep problems you are experiencing

3. How many times a week do you excercise?

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6+

What types of excercise do you participate in?

4. Do you experience overwhelming sadness, grief or depression?

○ Never ○ Rarely ○ Sometimes ○ Frequently ○ Always

How long have you experienced this?

5. Do you experience anxiety, panic attacks or have any phobias?

○ Never ○ Rarely ○ Sometimes ○ Frequently ○ Always

How long have you experienced this?

6. Do you experience any chronic pain?

○ Never ○ Rarely ○ Sometimes ○ Frequently ○ Always

Please describe this

7. How many times a week do you drink alcohol?

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6+

8. How often do you engage in recreation drug use?

○ Never ○ Rarely ○ Monthly ○ Weekly ○ Daily

9. Are you experiencing any appetite or eating problems? ☑ Yes ☐ No

Please describe this

10. Are you in a romantic relationship? ☐ Yes ☐ No

For how long?

11. How would you rate your relationship?

○ Poor ○ Okay ○ Good ○ Very Good ○ Excellent

12. What significant life changes/stressful events have you experienced recently?

13. Are you currently experiencing suicidal ideation? ☑ Yes ☐ No

14. Have you recently experienced any self-harm episodes? ☐ Yes ☐ No

15. Have your experienced any type of abuse or trauma? e.g. family violence, physical abuse, psychological abuse, sexual abuse, ongoing bullying, near death experience, home invasion, natural disaster etc ☐ Yes ☐ No

Family History

Has any of the below been diagnosed within your family?

			Family Member
Alcohol/Substance Abuse	☑ Yes	☐ No	
Anxiety	☐ Yes	☐ No	
Depression	☐ Yes	☐ No	
Domestic Violence	☐ Yes	☐ No	
Eating Disorders	☐ Yes	☐ No	
Obesity	☐ Yes	☐ No	
Obsessive Compulsive Behaviour	☐ Yes	☐ No	
Schizophrenia	☐ Yes	☐ No	
Suicide Attempts/Suicidal Ideation	☐ Yes	☐ No	
Borderline Personality Disorder	☐ Yes	☐ No	
Bi-Polar	☐ Yes	☐ No	
Dissociative Identity Disorder	☐ Yes	☐ No	he
Eating Disorders	☐ Yes	☐ No	
OCD	☐ Yes	☐ No	
PTSD	☐ Yes	☐ No	
	☐ Yes	☐ No	
	☐ Yes	☐ No	

Legal Status

Please tick ALL that apply:

- ☐ Family Legal Court Process
- ☐ Criminal Legal Process
- ☐ Civil Legal Process
- ☐ Other
- ☐ Apprehended Violence Order (AVO)
- ☐ Intervention Order (IO)
- ☐ None

Additional Information

What has made you seek out counselling?

What would you like to accomplish from counselling?

Please provide any additional information here