Counselling Intake Form

New client intake for a counselling practice. Completed by the client before or at the first session.

ORGANISATION

DATE

Client details

FULL NAME

PREFERRED NAME

DATE OF BIRTH

PRONOUNS

MOBILE

EMAIL

ADDRESS

POSTCODE

May we leave a voicemail or send appointment reminders?

- [ ] Voicemail OK
- [ ] SMS OK
- [ ] Email OK
- [ ] No messages

Emergency contact

NAME

RELATIONSHIP

PHONE

GP OR REFERRING PRACTITIONER

PRACTICE PHONE

What brings you here

IN YOUR OWN WORDS, WHAT WOULD YOU LIKE HELP WITH

HOW LONG HAS THIS BEEN GOING ON

WHAT HAS CHANGED RECENTLY

WHAT WOULD A GOOD OUTCOME LOOK LIKE FOR YOU

Background

Answer what you are comfortable with. You can leave anything blank and raise it later.

Have you had counselling or therapy before?

- [ ] Yes, currently
- [ ] Yes, previously
- [ ] No

IF YES, WHEN AND WITH WHOM

WHAT HELPED, WHAT DID NOT

CURRENT MEDICATIONS

PRESCRIBED BY

RELEVANT MEDICAL OR MENTAL HEALTH HISTORY

Current circumstances

LIVING SITUATION

WORK OR STUDY

WHO SUPPORTS YOU

Which of these are currently difficult (tick any)

- [ ] Sleep
- [ ] Appetite
- [ ] Concentration
- [ ] Energy or motivation
- [ ] Relationships
- [ ] Work or study
- [ ] Money
- [ ] Alcohol or other substances
- [ ] Anger
- [ ] Grief or loss
- [ ] Physical health
- [ ] Isolation

Practical matters

HOW DID YOU HEAR ABOUT THIS PRACTICE

REFERRED BY

PREFERRED APPOINTMENT TIMES

- [ ] Weekday morning
- [ ] Weekday afternoon
- [ ] Weekday evening
- [ ] Weekend

PREFERRED SESSION FORMAT

- [ ] In person
- [ ] Video
- [ ] Telephone

Consent and acknowledgement

- [ ] I have read and understood the practice privacy policy and confidentiality limits
- [ ] I understand the cancellation policy and the fee that applies to late cancellations
- [ ] I consent to my counsellor contacting my GP or referrer where clinically appropriate
- [ ] The information I have given is accurate to the best of my knowledge

CLIENT SIGNATURE

PRINT NAME

DATE