Therapy Intake Form

Clinical intake for a new therapy client. Covers presenting concerns, history, and consent in one document.

ORGANISATION

DATE

Client details

FULL NAME

DATE OF BIRTH

FILE NUMBER

PRONOUNS

MOBILE

EMAIL

ADDRESS

POSTCODE

EMERGENCY CONTACT NAME

RELATIONSHIP

PHONE

Referral and funding

REFERRAL SOURCE

- [ ] Self
- [ ] GP
- [ ] Psychiatrist
- [ ] Other health professional
- [ ] Family or friend
- [ ] Employer or EAP
- [ ] Insurer
- [ ] Online search

REFERRER NAME AND PRACTICE

REFERRAL DATE

PLAN OR CLAIM NUMBER

Presenting concerns

MAIN REASON FOR SEEKING THERAPY

ONSET AND DURATION

FREQUENCY AND INTENSITY

TRIGGERS NOTICED

IMPACT ON DAILY FUNCTIONING (WORK, STUDY, RELATIONSHIPS, SELF-CARE)

WHAT HAS HELPED SO FAR

WHAT HAS NOT HELPED

History

PREVIOUS THERAPY OR PSYCHIATRIC CARE

CURRENT MEDICATIONS AND DOSAGES

PRESCRIBER

MEDICAL CONDITIONS AND ALLERGIES

TREATING GP

FAMILY HISTORY OF MENTAL HEALTH CONCERNS

Current functioning

AREAS OF CURRENT DIFFICULTY

- [ ] Mood
- [ ] Anxiety or worry
- [ ] Sleep
- [ ] Appetite or eating
- [ ] Concentration
- [ ] Memory
- [ ] Intrusive thoughts
- [ ] Panic
- [ ] Trauma responses
- [ ] Relationships
- [ ] Work or study
- [ ] Substance use

SUPPORTS AND PROTECTIVE FACTORS

CURRENT STRESSORS

Goals

WHAT THE CLIENT WANTS TO BE DIFFERENT

Consent

- [ ] I have received and read the practice information sheet and privacy policy
- [ ] I understand the limits of confidentiality, including mandatory reporting and risk of harm
- [ ] I understand the fee structure, rebates available, and the cancellation policy
- [ ] I consent to assessment and treatment, and understand I may withdraw consent at any time
- [ ] I consent to relevant clinical information being shared with my GP or referrer

CLIENT SIGNATURE | PRINT NAME | DATE

CLINICIAN SIGNATURE | PRINT NAME | DATE