Welcome!
We need this information to provide you with the best quality of care. Your personal information is kept private and secure in accordance with federal and state legislation.

Client Registration

Full Name: ____
Last *First* *Title*

Address: ____
Street Address & PO BOX *Apartment/Unit #*

____
City *State* *Post Code*

Phone: ____________________ Email ____________________

Date of Birth: __________ Employer: __________ Occupation : __________

Relationship Status: ☐ Single ☐ Married/Partnership ☐ Widowed ☐ Separated/Divorced

Do you identify as Aboriginal? YES ☐ NO ☐ Do you identify as a Torres Strait Islander YES ☐ NO ☐

Are you of Non-English speaking background? YES ☐ NO ☐ If yes, what? ____________________

Have you been diagnosed with a disability? YES ☐ NO ☐ If yes, what? ____________________

Emergency Contact

Name: ____________________ Relationship: ____________________

Phone: ____________________

Can we discuss appointment times with this person? YES ☐ NO ☐

How did you hear about us?

☐ GP Referral ☐ EAP ☐ School ☐ Facebook ☐ Family/Friend ☐ Advertisement

Current Symptoms

☐ Sleep Disturbances ☐ Rapid or dramatic shifts in mood ☐ Changes in appetite ☐ Excessive Worry

☐ Change in sex drive ☐ Suicidal thoughts ☐ Loss of desire to participate in activities

Current Stressors

☐ Financial ☐ Work ☐ Health ☐ Family/Relationships ☐ Other____________________________

Personal / Family History

	YES	NO
Have you been diagnosed with a Mental Health condition?	☐	☐
If yes, (a) Do you take medication for the condition(s)?	☐	☐
If yes, please specify	____________________	
(b) Have you been hospitalised for the condition(s)?	☐	☐
Do you have a history of suicide attempt?	☐	☐
If yes, when was you most recent attempt?	____________________	
Is there a history of mental illness in your family?	☐	☐