CLIENT INTAKE FORM

Elaine Redford
COUNSELLING & PSYCHOTHERAPY

If you prefer, we can discuss any of the information in this form in person.

Personal Details

First Name:	Surname:	DOB:
Gender:	Occupation:	
Address:	Suburb:	State:
Email Address:		Phone Number:

Emergency Contact

Name:		Contact Number:
Alternative Contact:		
Permission to contact in case of emergency?	☐ Yes ☐ No	
Relationship to you:		

Health & Medical

GP Name:	Practice:
List any past or current medication:	
Previous Experience of Counselling/Psychotherapy and what you found helpful/unhelpful:	

Please select any conditions that you currently have or have had in the past:

☐ Anxiety or Panic	☐ Confidence or Self Esteem Issues	☐ Other (please name):
☐ Depression or Sadness	☐ Assertiveness or Anger Issues	
☐ Fears or Phobias	☐ Substance Dependency	☐ Any Physical Medical Conditions that impact your day-to-day life?
☐ Trauma/s	☐ Self Harm or Suicide Ideation	

CLIENT INTAKE FORM

Elaine Redford
COUNSELLING & PSYCHOTHERAPY

If you prefer, we can discuss any of the information in this form in person.

Other Information:

In a sentence or two, please describe what brings you to therapy at this time?

What are your best hopes & goals for therapy?

Is there anything else you think may be important for me to know?

Name:

Signature: **Date:**