RAYMA TORRESAN
•COUNSELLING•

INDIVIDUAL CLIENT INFORMATION

DATE____/_____/_____

Identification Information

Name_____ DOB_____/_____/_____

Address_____ Home Phone_____

City_____ State_____ Post Code_____

Work Phone_____ Mobile Phone_____

Email:_____

Can we leave a message on your: Work Home SMS Email

School_____

Occupation _____

Cultural/Racial Identification (i.e., Indigenous or TSI) _____

Legal Guardian/Parent Information (where applicable) OR Next of Kin/Emergency Contact (circle which)

Name_____ DOB_____/_____/_____

Relationship _____

Address_____ Home Phone_____

City_____ State_____ Post Code_____

Referral Information

Do you have a Mental Health Plan? Yes No

General Medical Practitioner Details:

Doctor Name:_____ Doctor Phone:_____

Who referred you to me?_____ Medical Practitioner Other

May I have your permission to thank this person for the referral? Yes No

(Please be aware that if you have a Mental Health Care Plan, this Clinician has reporting obligations to your General Medical Practitioner)

Medications:

Current Medications:	
Dosage:	
Frequency:	
Prescribing Physician:	

Family Information

Relationship Status: *(Please tick)*

Single
Married
Partner
Divorced
Widow/Widower

This is my: *(Please tick)*

1st		2nd		3rd		4th		Marriage/Partnershrship

Ages of children_____

_____

_____

Family history of: *(Please tick)*

Depression
Suicide Attempts
Anxiety
Eating Disorders
Mental Illness
Violence
Sexual Abuse
Emotional Abuse
Alcoholism/ Drug Addiction
Chronic Illness

Treatment Information

Reason for Visit? (If you prefer to discuss this in person, please leave this section blank)

Please indicate what major stressors you have had in the last twelve months? *(Please tick)*

Serious illness or injury
Death of a close friend or family member
Major illness in family
Gain of new family member
Divorce/separation/relationship ending
Job change
Other:

Have you ever received psychological services or counselling before? Yes No

If so, please describe when, from whom, purpose and the results:

Please check any of the symptoms/problems below that apply:

Please tick all that apply:

- Anxiety
- Depression
- Poor Anger Mgt
- Eating Disorder
- Gambling Problem
- Sex or Pornography
- Sleep Problems
- Addiction (drugs, alcohol, shopping, eating, etc)
- Unmanageable Stress
- Extended Family Problems
- Parenting Problems
- Financial Problems
- Work Problems
- Need to be perfect/being a perfectionist.
- Harming self
- Mental illness of a family member
- Recreational drug use
- Witnessing or being involved with a domestic violence situation.

Have you ever attempted or are you contemplating suicide? Yes No

If yes, please provide details:

_____

_____

_____

Do you have a history of hurting yourself, for example, through cutting or burning? Yes No

If so, please describe:

_____

_____

_____

What leisure activities / hobbies do you enjoy?

_____

_____

_____

What are your strengths?

_____

_____

_____

_____

How many hours do you work a week?

How many alcoholic beverages do you consume in a week?

Do you use illegal drugs? If yes, what and how much per day?

Do you smoke?

What is your occupation?

What is your education level?

How satisfied are you with your job/career?

Spiritual Affiliation

What is your religious affiliation?_____

How significant a role does spirituality play in your life? *(Please circle)*

None Somewhat Important Significant Very Significant

Cancellation Policy

Business hours are Monday – Friday

Please note that 24 business hours' notice is required to cancel or reschedule a session. Missed appointments, cancellations and rescheduling with less than 24 hours' notice will incur a full session fee.

Cancellation Policy Agreement

☐ I have read, understood and agree to the cancellation policy explained above.

Name / Sign _____

Confidentiality Statement

Under Australian law, counsellors are obliged to maintain client confidentiality.

Information about clients who seek counselling, the nature of the service provided, and the content of the counselling sessions, will not be disclosed without the permission of the client.

There are, however, some circumstances where exceptions apply. Counsellors may be required to disclose communications where the counsellor or practitioner reasonably believes that disclosure is necessary to:

- protect a child from the risk of physical, emotional or psychological harm;
- prevent or lessen a serious and imminent threat to the life or health of the client or other any person, including the threat of suicide; or
- Report the commission, or prevent the likely commission, of an offence involving violence or a threat of violence to the client or any other person.
- Comply with a law of the Commonwealth or a state or territory. This includes, for example, mandatory reporting of children at risk of harm either physical or emotional under state and territory laws and when client files are subpoenaed by a court of law.

As part of good practice, counsellors are required to undertake professional supervision with qualified and experienced therapists whose role is to guide and advise. Your case may be discussed in these circumstances as part of good case management. Your name will not be disclosed in accordance with maintaining your privacy and confidentiality.

Confidentiality Statement Agreement *

☐ I have read, understood and agree to the confidentiality statement explained above.

Name _____

Date _____