

Intake form

This form may take approximately 10 minutes to complete. Please answer as many questions as possible. You'll be able to discuss your answers in detail during the first session with your psychologist. Please put exclamation marks (!!) next to any questions that cause you to feel distressed.

Date form completed: _____

Name:		Home phone:	
Date of birth:		Mobile phone:	
Address:		Work phone:	
		Fax:	
		Email:	
Medicare No:		Medicare expiry date:	IRN (number next to your name on Medicare card):
Occupation:			
Emergency contact name:		Mobile phone:	
Home phone:		Work phone:	
Email:		Fax:	
GP name:	Provider No:	GP phone number:	GP fax:
GP address:		Date of referral and duration of referral:	
Briefly describe why you're coming to Key Psychology? What's the situation? What has happened?			
How would you rate these problems at the moment? (1 = mild, 10 = severe and overwhelming)			
What do you hope will be achieved with the psychologist's help? What are your goals?			
How often do you exercise, and for how long each time?			
Do you smoke pot or take other drugs? (Please describe drug use)			
Sleeping: At the moment my sleeping is: <input type="checkbox"/> pretty much the same as it has always been. <input type="checkbox"/> worse than normal. <input type="checkbox"/> better than usual.			
Comments?			



How much alcohol do you drink each week?

How many nights per week do you have more than 4 standard drinks?

Do you smoke cigarettes? Yes / No

If yes, how many smokes per day?

How much caffeine (coffee, Coke, etc) do you drink each day?

How many energy drinks each day?

Are you married / in a relationship? Yes / No

If yes, how long have you been together?

On a scale of 1 to 10 (1 = terrible, 10 = terrific), how would you rate this relationship?

Any kids? If yes, please list below:

Name of other parent	Child's name	Gender	Age	Resides with you?

Are you a member of any social groups / clubs / Church? Yes / No

If yes, please describe:

In the past year have you experienced any significant life changes? Yes / No

If yes, please describe:

Have you recently had thoughts about suicide? Yes / No

Any family history of mental illness? Yes / No

Have you previously been to a counsellor / psychologist? Yes / No

Have you previously been hospitalised for treatment of a psychological problem? Yes / No

Any health problems? Yes / No

If yes, please describe:

Are you currently taking any medication? Yes / No

If yes, please enter the details:

Medication	Dose	Prescribed for	How long been taking?

Have you experienced / been exposed to anything traumatic during your life? Yes / No

If yes, please describe:

What do you view as your strengths? What's going good in your life?