Outlook Psychology

New Client Form

Welcome!

We require 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

Title:_____

First Name:_____ **Last Name**: _____

Prefered Name: _____

Address (Street & Postal):_____

City/Town:_____ **State:**_____**Post Code**:_____

Phone/Mobile: _____**Work**: _____

Email: _____

Date Of Birth: ____/____/_____

Employer:_____

Occupation:_____

Relationship Status:

- Single
- Defacto/Relationship
- Married
- Widowed
- Separated/Divorced

Do you identify as Aboriginal? YES NO

Do you identify as Torres Strait Islander? YES NO

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Are you from a Non-English speaking background? YES NO

If yes, please specify?_____

Have you been diagnosed with a disability? YES NO

If yes, please specify?_____

EMERGENCY CONTACT

First Name:_____ Last Name:_____

Relationship: _____ Phone: _____

Can we discuss appointment times with this person? YES NO

HOW DID YOU HEAR ABOUT US?

- GP Referral
- EAP - Employee Assistance Program
- Facebook/Instagram - Social Media
- School
- 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: _____

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PERSONAL/FAMILY HISTORY

Have you ben diagnosed with a Mental Health condition? YES NO

If yes,
A) Do you take medication for the condition(s)? YES NO

If yes, please specify:_____

B) Have you been hospitalised for the condition(s)? YES NO

Do you have a history of suicide attempt? YES NO

If yes, when was your most recent attempt? YES NO

Is there a history of mental illness in your family? YES NO