:

CONFIDENTIAL CLIENT INTAKE FORM

DATE: ____/_____/ 20_____

1 CLIENT DETAILS:

FORM COMPLETED BY: _____ RELATIONSHIP TO CLIENT: _____

CLIENT NAME: _____ DOB: _____/_____/_____ GENDER: M/F

CONTACT PHONE: HOME - _____ MOBILE: _____

EMAIL ADDRESS:

_____

LANGUAGE SPOKEN AT HOME: _____ INTERPRETER REQUIRED: YES / NO

PREFERRED OPTION FOR COMMUNICATION: EMAIL LETTER PHONE

PLEASE NOTE: INVOICES FOR SERVICE DELIVERY WILL BE SENT VIA THE EMAIL ADDRESS STATED ABOVE, UNLESS DIRECTED OTHERWISE

RESIDENTIAL ADDRESS:

_____

FOR CLIENTS UNDER 18 YEARS OF AGE, UNDER GUARDIANSHIP OR IN THE CARE OF FAMILY OR CAREGIVERS, PLEASE COMPLETE DETAILS BELOW

NAME OF PARENT/GUARDIAN 1: _____

OCCUPATION: _____

a) PRIMARY CARER: YES / NO B) LIVES WITH CLIENT: YES / NO C) EMERGENCY CONTACT: YES / NO

RELATIONSHIP TO CLIENT: PARENT / CAREGIVER / GUARDIAN / OTHER _____

RESIDENTIAL ADDRESS: AS ABOVE, OR_____

CONTACT PHONE: HOME - _____ MOBILE- _____

EMAIL: _____

_____

NAME OF PARENT/GUARDIAN 2: _____

OCCUPATION: _____

b) PRIMARY CARER: YES / NO B) LIVES WITH CLIENT: YES / NO C) EMERGENCY CONTACT: YES / NO

RELATIONSHIP TO CLIENT: PARENT / CAREGIVER / GUARDIAN / OTHER _____

:

Residential Address: As Above, or_____

Contact Phone: Home - _____ Mobile- _____

Email: _____

2. Is there a Guardianship and / or Administration order in place? Yes / No

If yes please provide a copy of the guardianship and / or Administration order

3 Disability / Medical Conditions including any diagnosis if relevant:

Condition 1:

_____

_____

Condition 2:

_____

_____

Condition 3:

_____

_____

4 Health Care Information:

Medicare Number: _____ Exp: _____ Ref Number _____

Private Healthcare Provider: _____

Membership Number: _____ Ref Number _____

GP name: _____ PHONE: _____

Address: _____

5. Other Service Providers eg: Specialists, Childcare, School, and Therapy Providers

Name: _____ Phone: _____

Address: _____

Frequency: _____

:

NAME: _____ PHONE: _____

ADDRESS: _____

FREQUENCY: _____

NAME: _____ PHONE: _____

ADDRESS: _____

FREQUENCY: _____

6. FUNDING:

NDIS MANAGED? YES / NO

A COPY OF THE NDIS PLAN MUST BE PROVIDED FOR NDIA OR ID MANAGED CLIENTS

NDIS NUMBER: _____

NDIS DATES: _____

SELF-MANAGED? YES / NO PLAN MANAGED? YES / NO

_____

DVA MANAGED? YES / NO

A COPY OF THE DVA PLAN MUST BE PROVIDED

DVA NUMBER: _____

DVA DATES: _____

PLEASE PROVIDE CONTACT NAME AND EMAIL FOR INVOICES:

NAME: _____

EMAIL: _____

NOTES: _____

_____

7. PREFERENCES

:

Religious requirements: _____

Cultural requirements: _____

Devices for communication: _____

Access needs into service: _____

8. Source:

How did you hear about Bayside Counselling & Family Therapy?

- ☐ Google
- ☐ Facebook
- ☐ NDIS
- ☐ GP/ Specialist
- ☐ Family / Friend
- ☐ Other Provider _____
- ☐ OTHER _____

I give permission for Paula Johnstone from Bayside Counselling & Family Therapy to act as a consultant:

- To seek all relevant information as required from schools, clinics, and other educational and health services;
- To provide us/ me and any other professionals/services involved, with advice and assistance with
- Educational/ behavioural programs that are appropriate and relevant;
- We/I understand that the service will provide us/me with any reports and assessments and that we/I as parent/s or guardian/s will be full participants in any and all decisions which might be made about our child;
- We/I understand that all material will be treated with respect for our rights to privacy and confidentiality;
- I hereby consent to inclusive Directions maintaining records (either paper or electronic format) about the services provided

Signature of Client or Parent/Caregiver: _____

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I UNDERSTAND THAT:

- THESE RECORDS ARE OWNED BY BAYSIDE COUNSELLING & FAMILY THERAPY
- I CAN ASK TO SEE RECORDS AND RECEIVE A COPY;
- RECORDS ARE ARCHIVED BY BAYSIDE COUNSELLING & FAMILY THERAPY FOR A SET PERIOD OF TIME ACCORDING TO POLICY AND WILL EVENTUALLY BE DESTROYED;
- PHOTS/VIDEO FOOTAGE MAY BE KEPT IN RECORDS BUT WILL NOT BE USED FOR ANY OTHER PURPOSE WITHOUT CONSENT;
- I UNDERSTAND THAT ALL INFORMATION OBTAINED WILL BE KEPT CONFIDENTIAL.

TO THE BEST OF MY KNOWLEDGE, THE INFORMATION PROVIDED IN THIS FORM IS TRUE AND CORRECT.

SIGNATURE OF CLIENT OR PARENT/CAREGIVER: _____

NAME: _____ DATE: _____

RELATIONSHIP TO CLIENT: _____

THANK YOU