Confidential Client Information Form

NAME: .....

POSTAL ADDRESS: .....

..... POST CODE: .....

PHONE: Home ..... Mobile .....

Work .....

E-MAIL ADDRESS: .....

It is important that I am aware of your state of health - physically, emotionally and mentally. Certain conditions may limit your participation in particular processes for your own well-being. Some Expressive Therapy processes may not be appropriate during pregnancy, or for persons with cardiovascular problems, severe hypertension, severe mental illness, recent surgery or fractures, acute infectious illness, or epilepsy. Expressive Therapies and Sandplay Therapy are not compatible with the use of illegal drugs. The answers to the following questions are to assist me and will be kept strictly confidential (see over for exceptions).

OCCUPATION: .....

RELATIONSHIP STATUS:

Single ..... Partnered..... Separated ..... Divorced ..... Widowed .....

CHILDREN: .....

Type of delivery &/or any complications at their births: .....

.....

.....

YOUR BIRTH DETAILS:

Date of birth ..... Type of delivery &/or any complications .....

.....

.....

If not born in Australia – what is your country of origin .....

What age did you come to Australia .....

FAMILY OF ORIGIN:

Parents cultural heritage .....

If both/either of your parents have passed, when did they die? Mother ..... Father .....

Bought up by: Both Birth Parents..... Mother..... Father..... Step-Mother..... Step-Father .....

Adopted ..... Orphaned ..... Fostered ..... Other .....

Number of siblings: Brothers ..... Sisters ..... What number child where you .....

Any half or step brothers/sisters?.....

.....

.....

Have any of your siblings died? If so how and when .....

.....

Tick a **yes** or **no** answer to each question and elaborate on any question to which you answered "yes".

QUESTION	**NO**	**YES – DETAILS**
1. Do you have a past history of, or currently suffer from any of the following:		
a) Cardiovascular disease, including heart attacks		
b) High blood pressure		
c) Severe mental illness		
d) Recent surgery		
e) Past or recent physical injuries, including fractures or dislocations		
f) Recent or current infectious or communicable diseases		
g) Glaucoma		
h) Retinal detachment		
i) Epilepsy		
j) Osteoporosis		
k) Asthma - If yes, bring inhaler.		
l) Diabetes		
m) Cancer		
n) HIV		
o) Hepatitis		
2. Are you currently pregnant?		
3. Have you ever been hospitalized for medical reasons?		
4. Have you ever been psychiatrically hospitalized?		
5. Are you currently taking any prescribed medications?		

ANY RELATIONSHIP CHANGES IN LAST 2YRS? eg. separation, severe illness, death: .....
.....
.....

ANY LIFESTYLE CHANGES IN LAST 2YRS? eg. career, home: .....
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.....

IS THERE A FAMILY HISTORY OF MENTAL ILLNESS? If yes, details:.....
.....
.....

ANY FAMILY/SELF HISTORY OF ADDICTIONS &/OR CURRENT USE OF, MIND ALTERING OR ILLEGAL DRUGS? If yes, details: .....
.....
.....

HAVE YOU USED MIND ALTERING OR ILLEGAL DRUGS WITHIN THE PAST 3MTHS? If so, what: .....
.....

DO YOU HAVE A HISTORY OF VIOLENCE? VICTIM &/OR PERPETRATOR? eg. abuse, assault, incest, rape:
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FURTHER COMMENTS OR ANY OTHER INFORMATION REGARDING YOUR PHYSICAL, EMOTIONAL, OR MENTAL STATE OF HEALTH: .....
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IF YOU ARE UNDER THE CARE OF A MEDICAL DOCTOR AND I NEED TO CONTACT THEM WOULD I HAVE YOUR PERMISSION TO SPEAK WITH THEM? ..... (If yes, please give name and contact details of doctor)
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ANY OTHER TYPES OF COUNSELLING/THERAPY OR PERSONAL GROWTH WORK THAT YOU HAVE DONE PREVIOUSLY, OR ARE INVOLVED IN NOW: .....
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.....

WHAT ARE THE MAIN ISSUES THAT YOU WANT TO ADDRESS: .....

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CONSENT

As part of providing a counselling/supervision service to you I will need to collect and record personal information to do with name, address, contact details and some on-going notes documenting what happens during the appointment. You may access the material in your file upon request.

CONFIDENTIALITY

All personal information gathered during your work with me will remain confidential except when:

1. It is subpoenaed by a court, or
2. Failure to disclose the information would place you and/or another person at risk, or
3. Your prior approval has been obtained to discuss this information with another person.

CONSULTATION FEE AND CANCELLATION FEE POLICY

Please note I have a $100 cancellation fee when less than 24 hours notice is given and this includes requests to reschedule appointments.

I am happy to reschedule appointments as long as I have more than 24 hours notice.

Full consultation fee will apply for last minute cancellations and rescheduling, or failing to attend appointment.

Fee for standard 1.5hr appointment is $155; 2hr appt $185; 1hr appt $130

($5 discount for cash payment at time of appt)

PLEASE READ AND SIGN THE FOLLOWING STATEMENT

I hereby confirm that I have read and understood the above information and have answered all questions completely and honestly, and I have not withheld any information.

SIGNATURE: ..... DATE: .....

EMERGENCY CONTACT PERSON: .....

RELATIONSHIP TO YOU: .....

THEIR CONTACT DETAILS: .....

ACKNOWLEDGEMENT OF NOTIFICATION

Yes, I have been given or emailed a copy of the *"Office Policy and Informed Consent Agreement for Counselling & Psychotherapy Services"* to read on (Date):_____

I, _____ acknowledge that I have read Karen Daniel's

"Office Policy and Informed Consent Agreement for Counselling & Psychotherapy Services"

and I understand and agree to comply with these policies.

_____ _____

Signature Date