DEBORAH GOULD

Clinical Psychologist

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Confidential Client Information Form

CONSENT

As part of providing a counselling/supervision service to you/your child I will need to collect and record some personal information 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.

GENERAL INFORMATION

NAME OF CHILD:

DATE OF BIRTH:

ADDRESS:

BOTH PARENT'S PHONE DETAILS: Home -
Mother - Mobile Father - Mobile

E-MAIL ADDRESSES:
Mother –
Father -

IF YOU PLAN TO CLAIM THE SESSIONS FROM MEDICARE OR YOUR HEALTH FUND, PLEASE PROVIDE DETAILS:

IF YOUR CHILD IS 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

PARENTS' NAMES:

SIBLINGS NAMES AND AGES:

EMERGENCY CONTACT PERSON:
THEIR CONTACT DETAILS:

In addition, there is information that I gather in the course of assessing your child to establish what would best enhance their wellbeing. Please fill in as much as you are comfortable with; we will discuss many of the issues in our first session together prior to my meeting with your child.

School:
Year:
Class:
Teacher's name:

Other services involved (working with child and/or family):

Previous psychological assessments or treatments:

HISTORY
PERSONAL Pregnancy, birth (as much info as possible eg, length of labour, assisted delivery)

FAMILY Big events, separations, special connections

TRAUMA

CURRENT FUNCTIONING
BIOLOGICAL
Please make any comments about your child's:
Development:

General physical health: pain (headaches, stomach aches...), mobility, sight, hearing, speech, eating, vitamin deficiencies, enuresis, encopresis, sleep difficulties

Medication:

PSYCHOLOGICAL

Please make any comments about your child's:
Attachment style:
Behavioural difficulties: eg anger, withdrawal, bullying
Attention difficulties:
Anxiety symptoms:
Post Traumatic Stress symptoms: intrusions, avoidance, hyperarousal
Depression symptoms:
Suicidal ideation:

SOCIAL

Please make any comments about your child's peer relationships, involvement in community

FAMILY

Please make any comments about the way your family relates together:

SKILLS AND INTERESTS

CONSULTATION FEE AND CANCELLATION FEE POLICY

Please note I charge a $100 cancellation fee when less than 24 hours notice is given. The full consultation fee will apply for last minute cancellations and rescheduling, or failing to attend appointment.

Fee for standard 1hr appointment is $155; 1.5 hr appointment is $200