Naomi Campling
Psychologist

Suite 8/100 Burnett Street Buderim
PO Box 5115 Sunshine Coast MC QLD 4560
Ph 0491 119 185
Fax 07 5476 4108
Email admin@ncpsych.com.au
Web www.ncpsych.com.au

CLIENT INTAKE QUESTIONNAIRE

Welcome! As part of beginning the therapy process, please take some time to complete this form. This information will help me to better understand your situation as we begin to find solutions. This information will remain confidential. Thank you.

Name	
Date of Birth	
Contact Phone number(s)	H Can we leave message? M Can we leave message?
Home address	
email address	
Who referred you?	
GP name and address	
Medicare number	Reference No
Occupation	
Marital status	
Emergency contact name **Relationship** **Phone number**	

Other persons living in your household

First and Last Name	Relationship	Age	Employer/ School	Position/ Grade In School

Family stressors

Please tick if you currently have, or have had any of the following concerns in the last 12 months

☐	Marital separation / divorce	☐	Legal problems
☐	Death in the family	☐	Medical Problems
☐	Financial difficulties	☐	Household move/ accommodation concerns
☐	Job change / difficulties	☐	Anxiety/depression
☐	Drug/alcohol	☐	Other stressful event
☐	Domestic violence/ trauma		

Have you had hospital stays for psychological concerns?
Yes ☐ No ☐ When: _____

Are you currently experiencing thoughts of harming either yourself or someone else?
Yes ☐ No ☐

Have you in the past experienced thoughts of harming either yourself or someone else?
Yes ☐ No ☐

Reasons for referral

What are the main reasons that you are seeking help?

What are the most important things that you think I should know?

How have you attempted to cope with these issues?

How long have you experienced these problems, or when did you first notice them?

What are your goals for therapy?

Have you participated in counselling or therapy in the past? If so, briefly describe.

Naomi Campling, Psychologist PO Box 5115 Sunshine Coast MC QLD 4560 admin@ncpsych.com.au

Medical History

Rate your current physical health

Are you being treated for a medical problem and/or disability? Yes ☐ No ☐

Current medications

Past medications

Substance use

Do you drink alcohol? Yes ☐ No ☐

If so, how much, and how often

Do you use drugs? Yes ☐ No ☐

If so which drugs do you use and how often do you use them?

Do you smoke cigarettes? Yes ☐ No ☐

If so how much are you smoking a day?

Do you drink coffee? Yes ☐ No ☐

If so how much are you drinking a day?