BMD Psychology Consulting

Toolkits for Life

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Confidential Intake Form

We want to make the best use of your time during sessions, so we ask you to think about these questions prior to your first appointment. This information helps us understand you better so we can develop a good plan to help you. We will talk about your answers in more detail in session, this form is just a way to get the process started.

If you can, please read and write down answers to the questions before you come in and bring the completed form with you to the first session. If you find it hard to complete this form for any reason, don't worry. We will work through it together at your first session.

Personal Details

Person 1

Title: _____ Given Name: _____ Family Name: _____

Date of Birth: _____ / _____ / _____ Gender: _____ Age: _____

Address: _____ Post Code: _____

Occupation: _____

Home Phone Number: _____ Mobile Phone Number: _____

Email: _____

Emergency Contact: _____ Relationship to you: _____

Contact number (in the event of a medical emergency): _____

Medicare No: _____ Expiry Date: _____ Reference No: _____

Person 2

Title: _____ Given Name: _____ Family Name: _____

Date of Birth: _____ / _____ / _____ Gender: _____ Age: _____

Address: _____ Post Code: _____

Occupation: _____

Home Phone Number: _____ Mobile Phone Number: _____

Email: _____

Emergency Contact: _____ Relationship to you: _____

Contact number (in the event of a medical emergency): _____

Medicare No: _____ Expiry Date: _____ Reference No: _____

Do you intend to access Medicare rebates for your sessions? ☐ yes ☐ no

If yes - please be aware you will need a GP referral and a Mental Health Treatment Plan to bring to your first session.

Do you intend to access Medicare EasyClaim (immediate Medicare rebates via EFTPOS terminal): ☐ yes ☐ no

If yes – please ensure you have lodged your bank account details with Medicare prior to your first session.

Do you have private health insurance? ☐ yes ☐ no

Company: _____ Policy Type: _____ Member No: _____

Do you intend to claim on your private health insurance for your sessions? ☐ yes ☐ no

If yes – please be aware you cannot also claim Medicare.

Referring GP Details (if attending under a MH Treatment Plan and accessing Medicare rebates)

GP Name: _____

Practice Name: _____

GP Medicare provider Number: _____

Referral Source

How did you hear about BMD Psychology Consulting?

☐ APS Find A Psychologist website

☐ Other health services website name: _____

☐ Google searched for: _____

☐ GP or other health practitioner name: _____

☐ Friend or family member name: _____

☐ Other, somewhere else details: _____

Primary Concern

What is/are the primary concern(s) that brought you to seek assistance from a psychologist at this time, what are the symptoms associated with this and how disruptive is this to your psychological wellbeing (or to your relationship for couples)?

_____

_____

_____

Onset

When did you first notice this concern, what else was happening at that time that might be important?

_____

_____

_____

Course

What has happened since then, what have you already tried in order to help solve this problem? _____

_____

_____

_____

_____

Goals for Counselling

In your own words, what are the main goals or objectives you want to achieve by the end of your counselling?

_____

_____

_____

_____

_____

_____

Current Difficulties (Couple)

Please read this list slowly and circle all items which you are currently having difficulty or problems with.

1. Lack of intimacy
2. Sexual intimacy issues
3. Communication
4. Assertiveness
5. Parenting
6. Finances/money
7. Alcohol/substance abuse
8. Religious/spiritual differences
9. Personal growth/development
10. Physical health issues
11. Body image issues
12. Infidelity
13. Identity confusion
14. Childhood abuse issues
15. Aggressive behaviour
16. Stalking
17. Conflict/fighting
18. Household management
19. Loss/death of a significant person
20. Pregnancy / abortion / miscarriage issues
21. Relationship violence (emotional, physical, sexual)
22. Managing family relationships
23. Differences in family/cultural background
24. Other: _____ _____

Current Difficulties (Individual – Person 1)

Please read this list slowly and circle all items which you are currently having difficulty or problems with.

1. Trouble concentrating
2. Anxiety
3. Feeling panicky
4. Nervousness
5. Uneasy in crowds
6. Scared for no reason
7. Excessive worrying
8. Mind going blank
9. Fearful
10. Scared of a particular thing
11. Thoughts and speech getting mixed up
12. Impulse to repeat certain behaviours
13. Avoiding places because they are frightening
14. Often feeling like your heart is racing
15. Feeling jumpy
16. Awakening during night or earlier than usual
17. Having no interest in things
18. Crying more often than usual
19. Unable to have a good time
20. Tired most of the time
21. Feelings of hopelessness
22. Recent weight loss
23. Recent weight gain
24. Feeling worthless
25. Feeling more irritable than usual
26. Feeling down
27. Feeling depressed
28. Feeling others are to blame for things
29. Others not giving proper credit for your work
30. Having ideas or beliefs others don't share
31. Feeling most people can't be trusted
32. Others taking advantage of you (if you let them)
33. Being watched or talked about
34. Feeling weak in parts of your body
35. Dizziness or faintness
36. Feeling a lump in your throat
37. Being out of breath or hard to get your breath
38. Poor appetite
39. Nausea or upset stomach
40. Trouble with vision or hearing
41. Change of sensation in part of body
42. Headaches
43. Tremors or shaking
44. Hot or cold spells
45. Bothered by unusual odours
46. Having thoughts that are not your own
47. Travelling somewhere without knowing how you got there
48. Feeling things are unreal or not real
49. Feeling you are not real
50. Hearing voices others do not hear
51. Feeling something is wrong with your mind
52. Never feeling close to another person
53. Having strange and peculiar experiences
54. Seeing things others don't see
55. Feeling 'on top of the world' for no reason
56. Getting by on little sleep
57. Trouble controlling your impulses
58. Feeling like you have special abilities or powers
59. Restlessness
60. Urges to smash or break things
61. Urges to harm someone
62. Temper outbursts
63. Easily irritated
64. 'Losing it' – aggression
65. Being a hothead
66. Feelings of 'wanting to end it all'
67. Having made a suicide attempt
68. Wanting to hurt yourself or doing so
69. Financial problems
70. Unhappy with current job
71. Having an unwanted habit
72. Unable to find/keep a job
73. Difficulty in school
74. Difficulty reading/writing
75. Using drugs
76. Legal problems
77. Using alcohol
78. Getting along with others
79. Feeling inferior to others
80. Worried about sex matters
81. Relationship issues
82. Home conditions not good
83. Trouble making decisions
84. Feelings are easily hurt
85. Having been abused
86. Communicating

Current Difficulties (Individual – Person 2)

Please read this list slowly and circle all items which you are currently having difficulty or problems with.

1. Trouble concentrating
2. Anxiety
3. Feeling panicky
4. Nervousness
5. Uneasy in crowds
6. Scared for no reason
7. Excessive worrying
8. Mind going blank
9. Fearful
10. Scared of a particular thing
11. Thoughts and speech getting mixed up
12. Impulse to repeat certain behaviours
13. Avoiding places because they are frightening
14. Often feeling like your heart is racing
15. Feeling jumpy
16. Awakening during night or earlier than usual
17. Having no interest in things
18. Crying more often than usual
19. Unable to have a good time
20. Tired most of the time
21. Feelings of hopelessness
22. Recent weight loss
23. Recent weight gain
24. Feeling worthless
25. Feeling more irritable than usual
26. Feeling down
27. Feeling depressed
28. Feeling others are to blame for things
29. Others not giving proper credit for your work
30. Having ideas or beliefs others don't share
31. Feeling most people can't be trusted
32. Others taking advantage of you (if you let them)
33. Being watched or talked about
34. Feeling weak in parts of your body
35. Dizziness or faintness
36. Feeling a lump in your throat
37. Being out of breath or hard to get your breath
38. Poor appetite
39. Nausea or upset stomach
40. Trouble with vision or hearing
41. Change of sensation in part of body
42. Headaches
43. Tremors or shaking
44. Hot or cold spells
45. Bothered by unusual odours
46. Having thoughts that are not your own
47. Travelling somewhere without knowing how you got there
48. Feeling things are unreal or not real
49. Feeling you are not real
50. Hearing voices others do not hear
51. Feeling something is wrong with your mind
52. Never feeling close to another person
53. Having strange and peculiar experiences
54. Seeing things others don't see
55. Feeling 'on top of the world' for no reason
56. Getting by on little sleep
57. Trouble controlling your impulses
58. Feeling like you have special abilities or powers
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61. Urges to harm someone
62. Temper outbursts
63. Easily irritated
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75. Using drugs
76. Legal problems
77. Using alcohol
78. Getting along with others
79. Feeling inferior to others
80. Worried about sex matters
81. Relationship issues
82. Home conditions not good
83. Trouble making decisions
84. Feelings are easily hurt
85. Having been abused
86. Communicating

Background

Where did you (each) grow up (0-18 years)? _____

_____

Who did you (each) live with during this time? _____

_____

If you (each) had/have siblings, how old are they in comparison to you? _____

_____

How was primary school for (each of) you? _____

_____

How was high school for (each of) you? _____

_____

How did you (each) get on with other people? _____

_____

_____

How was (each of) your health growing up? _____

_____

_____

Any other important information or comments about this time in (each of) your life? _____

_____

_____

_____

Relationships & Social Connections

Person 1

Do you identify as:

☐ straight ☐ gay ☐ transgender ☐ queer ☐ bi ☐ lesbian ☐ bisexual ☐ intersex ☐ rather not say

Person 2

Do you identify as:

☐ straight ☐ gay ☐ transgender ☐ queer ☐ bi ☐ lesbian ☐ bisexual ☐intersex ☐ rather not say

Person 1

Overview of intimate relationships (age, duration, satisfaction with the relationship)? _____

_____

_____

Current relationship status:

☐ single ☐ married ☐ partnered ☐ separated ☐ divorced ☐ widowed

Current partner (first name or n/a) _____ Age ____ Years in relationship _____

Children: ☐ yes ☐ no If yes (gender/age): _____

Other important information: _____

Person 2

Overview of intimate relationships (age, duration, satisfaction with the relationship)? _____

_____

_____

Current relationship status:

☐ single ☐ married ☐ partnered ☐ separated ☐ divorced ☐ widowed

Current partner (first name or n/a) _____ Age ____ Years in relationship _____

Children: ☐ yes ☐ no If yes (gender/age): _____

Other important information: _____

Physical Health & Medical History

Significant current or past medical problems for (each of) you (injuries and/or illnesses/diagnoses):

_____

_____

Current medications for (each of) you (prescription & over-the-counter medications and the dosage of each):

Do (either of) you have any health alerts: ☐ yes ☐ no Details:

Mental and Emotional Wellbeing

Have (either of) you had previous psychological care or counselling/therapy? ☐ yes ☐ no

If yes, please note when (e.g., Nov 12 - Feb 13), what kind of therapist you saw, the nature of the issues addressed at the time (including any diagnoses made), and whether it was helpful or not and why:

Have (either of) you ever been hospitalised for a psychological difficulty? ☐ yes ☐ no

If yes, please give the dates and the nature of the difficulties at the time (including any diagnosis made):

Do (either of) you have close family members with mental health problems or diagnoses? ☐ yes ☐ no

Is there anything else we should know about (either of) your emotional and mental health? ☐ yes ☐ no

Other Information

Do (either of) you ever gamble? ☐ yes ☐ no

If yes (which of you, what kind, what is the main reason you do it, do you think it creates problems in your life?)

_____

_____

Do (either of) you have any convictions and/or current charges? ☐ yes ☐ no

Previous incarcerations? ☐ yes ☐ no

_____

_____

Do (either of) you ever use substances (complete below):

	Never ✓	**Ever** Y/N	**In past 3 months** Y/N	**Details** including frequency (e.g., daily/weekly), volume, method, why you use it
Tobacco products (cigarettes, chewing tobacco, cigars, etc.)				
Alcoholic beverages (beer, wine, spirits, etc.)				
Cannabis (marijuana, pot, grass, hash, etc				
Cocaine (coke, crack, etc.)				
Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)				
Inhalants (nitrous, glue, petrol, paint thinner, etc.)				
Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)				
Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)				
Opioids (heroin, morphine, methadone, codeine, etc.)				
Caffeine (coffee, tea, coca cola, V, Red Bull)				

Work & Education

Person 1

Are you currently employed? ☐ yes ☐ no Position/Role: _____

Do you have any specific comments about your current work situation? ☐ yes ☐ no

_____

_____

Educational background (year/grade completed, qualifications):

_____

_____

Person 2

Are you currently employed? ☐ yes ☐ no Position/Role: _____

Do you have any specific comments about your current work situation? ☐ yes ☐ no

_____

_____

Educational background (year/grade completed, qualifications):

_____

_____

Other Comments & Questions

Do (either of) you have any other comments or important information you would like to provide?

_____

_____

_____

_____

Do (either of) you have any questions you would like to make sure we cover off in your first session? ☐ yes ☐ no

_____

_____

_____

_____

Thank you for completing the BMD Psychology Consulting Intake Form.