Grow Support Incorporated

# Intake Form

**Client Full Name**: _____**DOB**: _____

**Gender**: ☐Male ☐ Female ☐Transgender Female (Male-To-Female) ☐Transgender Male (Female-To-Male) ☐Non-Binary ☐Other: _____

**Street Address**: _____**Suburb**: _____

**Postcode**: _____ **Home Phone**: _____ **Mobile**: _____

**Email**: _____

**Other Significant People**: _____

Referred From:
☐ LDS ☐ Doctor ☐ Community ☐ NDIS ☐ Other_____

Payment Details:
☐ Bishop ☐ Medicare ☐ NDIS ☐ Wesley Mission ☐ Self ☐ Other_____
☐ Gap Fee_____

**Contributing factors for presentation** (all that apply):

| | | |
|---|---|---|
| ☐Child safety interactions | ☐Serious accident / injury. | ☐Alcohol/drug related problems |
| ☐Grief / loss | ☐Physical Disability | ☐Intellectual disability |
| ☐Divorce or separation | ☐Sexual assault/abuse | ☐Unable to secure employment |
| ☐Legal / corrections issues. | ☐Suicidal Ideation. | ☐Gambling problem / other addiction |
| ☐Discrimination | ☐Trauma | ☐Bullying and/or harassment |
| ☐Self Harm | ☐Domestic Violence | ☐Chronic disease:_____ |

☐Other, specify: _____

I agree to information about my mental health and well-being to be shared between the counsellor and person whom I am referred (and/or as indicated below), to assist in the management of my health care. I am also aware information may be viewed for organisational audits and accountability.
☐ Doctor ☐Bishop ☐Case Manager ☐Parent ☐Other_____
☐ Not to be shared with anyone

I am aware that statistical information (which **does not** identify individuals) is being collected and used to assist in improving services, and I agree to this de-identified information being collected.

*Grow Support Inc*
*PO Box 6204, Logan Central Qld 4114*
*Ph: 07 3472 5880*
*Email: contact@growsupport.net.au*

As a Clinician, I have discussed the Intake Form with the client and am satisfied that the client understands the proposed uses and disclosures and has provided their informed consent to these.

Sessions may be recorded for accuracy and for Clinician use only.

Client Signature: _____
(or Client Representative)
Client Representative Name: _____

Representative Relationship to Client: _____

Clinician Name: _____

Clinician Signature: _____

Please note: Grow Support Inc may invite you to complete a survey about your counselling experience. Your feedback will help us to monitor and maintain a high-quality professional counselling service.

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