Connections WA

Adult Intake Form

About this form

This form is for you, to tell us more about yourself before you attend your first session with your therapist. Please provide as much information as you can. Thank you, from the Connections WA team.

About You

Client Name		**Surname**	
Preferred name		**Pronouns**	
DOB		**Your mobile**	
Next of Kin: name		**Next of Kin: mobile**	

Have you had suicidal thoughts recently?	**Frequently ( ) Sometimes ( ) Rarely ( ) Never ( )**
Have you had them in the past?	**Frequently ( ) Sometimes ( ) Rarely ( ) Never ( )**
Are you currently in a romantic relationship?	**Yes ( ) No ( )**
How would you rate your current relationship on a scale of 1-10? (10 is high)	
In the last year, have you experienced significant life changes/stressors?	
Do you consider yourself to be religious?	**Yes ( ) No ( ) If yes, what is your faith?**
If no, you consider yourself to be spiritual:	**Yes ( ) No ( )**

Therapy history

Are you **currently** receiving psychiatric services or professional psychology/occupational therapy elsewhere? If so, please provide the therapist's name.		Have you **previously** received psychiatric services or professional psychology/occupational therapy elsewhere? If so, please provide the date and therapist's name.	

Are you currently taking prescribed psychiatric medications (antidepressants or others)?

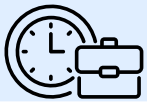
Yes ( ) No ( ) If yes, please list, the dose and frequency:

Who is your primary GP:		**Which practice?**	

Please list any persistent physical symptoms or health concerns (chronic pain, diabetes, etc)

Current living situation? (parents, partner, children):

Occupational Information



Are you currently employed? Yes ( ) No ( )

If yes, who is your current employer and position?

Please list any work-related stressors, if any:

Your Health

Are you having any problems with your sleep?
Yes ( ) No ( ) Sleeping too little ( ) Sleeping too much ( ) Poor quality sleep ( ) Disturbing dreams ( ) Other ( )
Are you having any difficulty with appetite or eating habits?
Yes ( ) No ( ) Eating less ( ) EAting more ( ) Restricting ( ) Bingeing ( ) Other ( )
Any significant weight changes in the last 2 months?
Yes ( ) No ( ) Please details:
Do you regularly use alcohol?
Yes ( ) No ( ) In a typical week, how much do you drink?
Do you engage in recreational drug use?
Daily ( ) Weekly ( ) Monthly ( ) Rarely ( ) Never ( )
Do you smoke cigarettes, or use other tobacco products?
Yes ( ) No ( )
How many times per week do you exercise and for how long?

1, What do you consider to be your strengths?
2, What are effective coping strategies that you have learned?
3, What are your current concerns you would like us to help you with? What are your goals for therapy?

Thank you, for providing this information, please send to info@connectionswa.com.au We look forward to working with you. The Connections WA team.