

IFS CLIENT INTAKE FORM

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Date: \_\_\_\_\_\_ /\_\_\_\_\_\_ /\_\_\_\_\_\_ Age: \_\_\_\_

Gender: □ Male □ Female □ Other

Relationship Status: \_\_\_\_\_\_\_\_\_\_

Number of Children: \_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mobile Phone: ( ) \_\_\_\_\_\_\_\_\_\_\_May we leave a message? □ Yes □ No

E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_May we email you? □ Yes □ No

Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TO HELP ME HELP YOU……**

Are you currently receiving mental health treatment from other providers? □ Yes □ No

If Yes, please provide details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you received mental health treatment previously?
□No

□Yes (Please provide details) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently taking prescribed psychiatric medication (antidepressants or others)? □No □Yes (Please provide details) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been previously prescribed psychiatric medication?
□No □Yes (Please provide details) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently using alcohol and or/drugs □ Yes □ No

If yes, what, and how frequently?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your goals for therapy? What would you like to address and/or achieve from this process?

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What exposure or experience have you had with IFS Therapy?

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Is there any other information you would like me know?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONFIDENTIALITY AGREEMENT**

Confidentiality is imperative in building a therapeutic relationship and we honor that always. The only time when your confidentiality will be waived is if you, or a person you know, are at serious risk of harm. In this instance appropriate authorities or family members will be notified.

N.B. As part of the professional code of conduct for counsellors, it is mandatory that I attend supervision sessions. During these sessions client cases might be presented however, the client’s name is protected.

Please be aware that this is not a crisis service and we are not available for emergency situations. Our work phones and emails are not attended outside of work hours, therefore in case of crisis or emergency please contact Lifeline on 13 11 14, kids helpline 1800 551 800, police or ambulance on 000.

**IFS Therapy sessions are 1hr $150, payment is due on the day of your appointment. These appointment are not reimbursable by medicare.**

**All appointments require 24hrs notice for cancellations to avoid the $75 late cancellation or missed appointment fee.**

Please sign here to state your understanding and agreement to the information provided.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­\_\_\_\_\_\_\_

**Fleurieu Counselling & Wellness**

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