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| --- | --- | --- |
| **New Client Information** | Date | Surname: |
| Given Names: | Preferred Name: |
| Date of Birth: / /  | Gender: M / F (circle) | Marital Status (client/guardian):  |
| *If under 18:* Name of parent(s)/guardian(s): |
| Residential Address: | Postcode |
| Postal Address (if different to above) |
| Email Address |
| Phone | Home: | Work: | Mobile: |
| Occupation/School (incl. Year Level): |
| Emergency contact  | Name: | Home: |
| Relationship: | Mob |
| Medicare Number: | Ref/Your Number | EXP: |
| Private Health Insurance Y / N | Health Fund Name: |
| Mental Health Care Plan Y/N | Date: | Referring GP: |
| Referring GP Provider Number & Practice Name\*: *\*Not required if referral from a Bellbowrie Family Practice Doctor.*  |
| Referral type(if known; please circle):  | Medicare Better Access / Brisbane MIND / WorkCover Qld / Self-Referral with Private Health / Self-Referral self-funded |
| Have you attended Counselling with another Psychologist in this calendar year? Yes/No *(please circle)*If yes please indicate the number of sessions attended in this calendar year\*:*\*Please be accurate (do not guess). You can check with Medicare Online; the item number will be 80110 or 80115.*  |
| How did you first find out about this Psychological Service? |
| What is your primary reason for seeing a Psychologist/what are you hoping to achieve from counselling? |
| ***Office use only:*** |
| Date | Notes |  |
| 1 |  | Assessment |
| 2 |  |  |
| 3 |  |  |
| 4 |  |  |
| 5 |  |  |
| 6  |  | Assessment/ Report  |
| 7 |  |  |
| 8 |  |  |
| 9 |  |  |
| 10  |  | Assessment/ Report |