Kairos Care

Client Psychotherapy Intake Form

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Client Details

Client Name: (Last, First, Middle Initial)

_____

Date of Birth: _____/_____/_____
DD MM YYYY

Gender: • Male
• Female

Martial Status:
- Never Married
- Domestic Partnership
- Married
- Separated
- Divorced
- Widowed

Address: (Street and Number) (City, State, Zip)

_____

_____

Please list any children/age:

_____

_____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
• Yes • No

Previous Therapist/Practitioner:

_____

Referred by (if any):

_____

Parent/Guardian Name: (If under 18 years)

_____

Age:_____

Home Phone: _____

Can we leave a message on your home phone? • Yes • No

Other Phone: _____

May we leave a message on your other phone? • Yes • No

Email: _____

May we email you?
*Please note: Email correspondence is not considered to be a confidential medium of communication.
• Yes • No

Are you currently taking any prescription medication? • Yes • No

Please list: _____

_____

_____

Have you ever been prescribed psychiatric medication? • Yes • No

Please list and provide dates:_____

_____

_____

General Health and Mental Health Information

1. How would you rate your current Physical Health?

•Poor • Unsatisfactory • Satisfactory • Good • Very Good

Please list any specific health problems you are currently experiencing:

2. How would you rate your current sleeping habits?

•Poor • Unsatisfactory • Satisfactory • Good • Very Good

Please list any specific sleep problems you are currently experiencing:

3. How many times per week do you generally exercise? _____

What types of exercise do you participate in? _____

4. Please list any difficulties you experience with your appetite or eating patterns:

5. Are you currently experiencing overwhelming sadness, grief, or depression?

• Yes • No

If yes, for approximately how long?

_____

6. Are you currently experiencing anxiety, panic attacks, or have any phobias?

• Yes • No

If yes, when did you begin experiencing this?

7. Are you currently experiencing any chronic pain?

• Yes • No

If yes, please describe:

8. Do you drink alcohol more than once a week?

• Yes • No

9. How often do you engage in recreational drug use?

• Daily • Weekly • Monthly • Never

10. Are you currently in a romantic relationship?

• Yes • No

If yes, for how long? _____

On a scale of 1-10, How would you rate your relationship? (1-Poor, 10 Very Good)

•1 •2 •3 •4 •5 •6 •7 •8 •9 •10

11. What significant life changes or stressful events have you experienced recently?

_____

_____

_____

_____

Family Mental Health History

Please answer and list family members.

a. Alcohol/Substance
• Yes • No
Family Member _____

b. Abuse
• Yes • No
Family Member _____

c. Anxiety
• Yes • No
Family Member _____

d. Depression
• Yes • No
Family Member _____

e. Domestic Violence
• Yes • No
Family Member _____

f. Eating Disorders
• Yes • No
Family Member _____

g. Obesity
• Yes • No
Family Member _____

h. Obsessive Compulsive Behavior
• Yes • No
Family Member _____

i. Schizophrenia
• Yes • No
Family Member _____

j. Suicide Attempts
• Yes • No
Family Member _____

Additional Information

1. Are you currently employed?

   • Yes • No

   If yes, what is your current employment situation?

   _____

   _____

   Do you enjoy your work? Is there anything stressful about your current work?

   _____

   _____

2. Do you consider yourself to be spiritual or religious?

   • Yes • No

   If yes, describe your faith or belief: _____

   _____

   _____

   _____

3. What do you consider to be some of your strengths?

   _____

   _____

   _____

4. What do you consider to be some of your weaknesses?

   _____

   _____

   _____

5. What would you like to accomplish out of your time in therapy?

   _____

   _____

   _____

Disclosure Forms

Please read the following carefully. These may be signed during your first session.

Limits of Confidentiality

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

**Duty to Warn and Protect*

When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

**Abuse of Children and Vulnerable Adults*

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

**Prenatal Exposure to Controlled Substances*

Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

**Minors/Guardianship*

Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

**Insurance Providers (when applicable)*

Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

Patient Name: _____

Date :_____/_____/_____(DD/MM/YYYY)

Signature: _____

Mode of Payment

For clients who are paying

- ***privately,*** we accept direct deposit, EFTPOS (debit and credit cards) and Afterpay
- via ***Private health fund*** (BUPA, Medibank, AHM, St Lukes, Police fund), we require full payment upfront and we issue a sales receipt upon completion of payment that you may use to reimburse with your health fund provider.
- *via* ***Medicare Mental Health Care Plan (MHCP),*** we require a gap payment of $80 and we coordinate directly with your GP
- *via* ***NDIS***, sessions are covered by the NDIS, depending on client's plan.

Cancellation Policy

If you fail to cancel a scheduled appointment, we cannot use this time for another client and you will be billed for the entire cost of your missed appointment. A full session fee is charged for missed appointments or cancellations with less than a 24-hour notice unless it is due to illness or an emergency. A bill will be mailed directly to all clients who do not show up for, or cancel an appointment.

Thank you for your consideration regarding this important matter.

Patient Name: _____

Signature: _____
Date:_____/_____/_____ (DD/MM/YYYY)