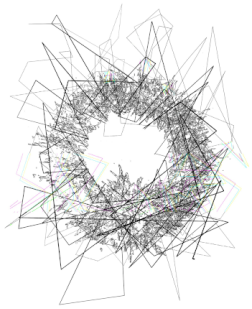


M.A.D Therapy Client Intake Form

< Adults >

Cover Page

Please answer ALL questions below

Name:

Best contact details: (mobile)

(email address)

Available day(s): ☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat

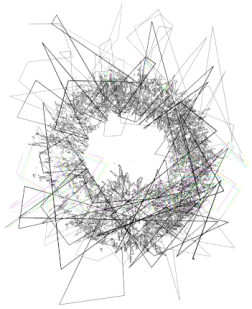
Specific time(s) if needed:

Therapies interested

☐ Music Therapy ☐ Arts Therapy ☐ Dance Movement Therapy

☐ AutPlay Therapy ☐ Counselling ☐ Resilience Coaching

Please be advised some therapists may be at capacity and there can be a wait period.



Leave blank any question you would rather not answer, or would prefer to discuss with your therapist. Information you provide here is held to the same standards of confidentiality as our therapy.

Your Information (client)

Full name:

Preferred name if called different:

Preferred pronoun: ◯ he ◯ she ◯ they ◯ other:

Date of birth: Age:

Residential address:

Contact number: Email:

(leave blank if you filled this in the cover page)

Country of origin: Year of migration:

Language(s) spoken at home: Religion (if any):

Do you need an interpreter? ◯ No ◯ Yes Profession:

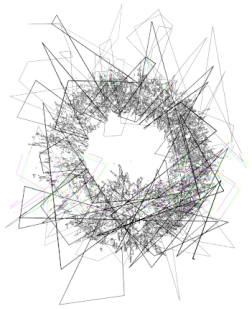
Therapy Information

Do you have any medical and/or mental health diagnosis? ◯ No ◯ Yes

If yes, please list them (and include what the year of diagnosis was):

Are you currently receiving any medication for the diagnosis? ◯ No ◯ Yes

If yes, please list them (and include how much and how regularly you receive):



Are you currently receiving any therapy/treatment for the diagnosis? ◯ No ◯ Yes

If yes, please list them (and include the therapists' names and contact details):

Please attach any recent reports/assessment documents or bring to initial consultation

Any family history of medical and/or mental health diagnosis? ◯ No ◯ Yes

If yes, please list them:

Do you have NDIS funding? ◯ No ◯ Yes

If yes, please write down the NDIS number: (Please send the NDIS plan and goals)

How is your NDIS fund managed?

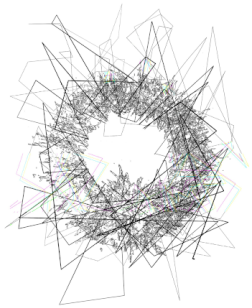
◯ Agency-Managed ◯ Plan Managed ◯ Self-Managed

Please list your plan manager's details if applicable:

Contact person or organisation :

Contact number:

Contact email address:



Any medication, allergy that may affect your attendance of therapy?

◯ No ◯ Yes

If yes, please describe:

Any history of incidental and/or emotional trauma? ◯ No ◯ Yes

If yes, please describe:

Do you expect any psycho-social risk in engaging in therapy such as aggression, damage of property and self harm or hurting others?

◯ No ◯ Yes

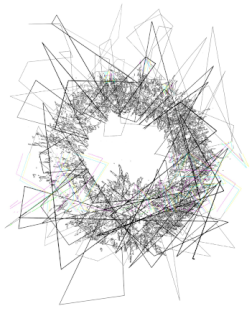
If yes, please describe:

Is there a current behaviour support plan? ◯ No ◯ Yes *(Please provide a copy)*

Your Emergency Contact

Full name: Relation:

Contact number: Email:



Preparing for therapy

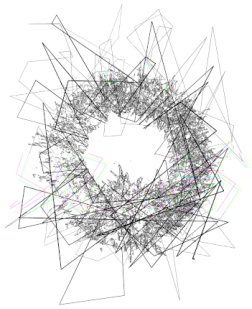
1. Please summarise the presenting issues that you would like to address in therapy:

2. Hobbies/interests/talents - how do you occupy free time?

3. Meaningful relationship(s) you have outside family

4. Please choose 5 words to describe your personality (both light and shadow)

(you can use this pdf to help you find the words)
https://www.longbranch.k12.nj.us/cms/lib/NJ01001766/Centricity/Domain/445/A-Z%20describing%20words.pdf



5. Any extra information you would like to supply to the therapist

<u>Therapy Goals</u>

What do you wish to achieve from engaging in therapy of your choice?

Small goals:

Big goals:

Confidentiality Policy and Consent Form

M.A.D Therapy is committed to ensuring appropriate confidentiality and privacy in matters relating to the information in which you share with us as a client of our service. In order to provide you with quality service, we may need to collect information about you to thoroughly assess, evaluate and provide therapy. This means we need to collect some personal information from you as well as some ongoing notes to document sessions.

Confidentiality

All personal information gathered by M.A.D Therapy during the provision of the services will remain confidential and secure except when:

1. It is subject to subpoena by a Federal Court, or
2. Failure to disclose the information would place you or another person at risk; or
3. Your prior approval has been obtained to discuss with another professional or agency (e.g. a GP, a teacher or other allied health/mental health professionals) or a non-professional person (e.g. a family member) to facilitate communication and best possible care and treatment for you

   M.A.D Therapists may want to discuss aspects of your personal information with peers and/or senior colleagues for supervision purposes in order to gain additional strategies to serve our clients' best possible treatment outcome. In this situation, our clients' anonymity would be preserved.

I, _____ :

- understand the reasons for the collection of my personal information and the ways in which the information may be used and disclosed and I agree to that use and disclosure.
- agree to commencing therapy service with therapists at M.A.D Therapy
- give permission to M.A.D Therapy to exchange information with other supporting professionals for the purposes of supporting me
- give my consent for my information being used (with anonymity) to support best practice.
- understand that it is my choice as to what information I provide and that withholding or falsifying information might act against the best interests of my assessment and therapy progress.
- am aware that I can access my personal and treatment information on request and if necessary, correct information that I believe to be inaccurate.

Print Name: _____

Signature:

Date: _____