Intake Form

Please complete the following form as accurately as possible. All information collected in this form will be kept private and confidential, in line with the Privacy Act 1988 (Cth), the Australian Privacy Principles, and Mindswell Therapy's Privacy Policy. By completing this form, you consent to Mindswell Therapy collecting and storing your information for the purposes of providing therapy and related services.

Please note: Information you provide will remain confidential except where disclosure is required by law (e.g., risk of harm to self or others, child protection concerns, or court orders).

All new clients, as well as returning clients who have not attended Mindswell Therapy for a period of 6 months, are required to complete the intake form at least 24 hours prior to their scheduled appointment. This helps us ensure we have the most accurate and up-to-date information to provide you with the best possible support.

Personal Details

First Name: _____ Surname: _____

Name on ID (if different): _____

Pronouns: _____ Date of Birth (DD/MM/YYYY): _____ / _____ / _____

Email: _____ Mobile: _____

Home Address: _____

Preferred Contact Method (circle all that apply): SMS / Email / Phone

Living Situation

With whom are you currently living? (Please list names, ages, and relationship):

_____

_____

_____

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Medical and Mental Health Information

Relevant Physical Health Issues (relevant to us working together):

_____

_____

_____

Please list any diagnosed Mental Health Conditions:

_____

_____

_____

Do you consider these diagnosed health conditions to be accurate? Yes / No

Do you have any accessibility requirements or preferences? _____

_____

GP Name: _____ Clinic: _____

GP Contact Details: _____

Emergency Contact Name: _____

Relationship to You: _____ Emergency Phone: _____

Cultural and Identity Information

Do you identify as Aboriginal and/or Torres Strait Islander? Yes / No

Do you identify as culturally or linguistically diverse? Yes / No

Preferred Language (if other than English): _____

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Engaging in Therapy

Have you previously consulted with: (tick what applies)

[ ] Counsellor [ ] Psychotherapist [ ] Psychologist [ ] Psychiatrist

What was helpful or unhelpful during those consultations?

_____

_____

_____

What prompted you to make this appointment?

_____

_____

_____

Are you likely to want to discuss spiritual issues? Yes / No / Unsure

If yes, please explain:

_____

_____

What do I need to know about you to best support you?

_____

_____

_____

Service and Payment Information

Who is responsible for payment? (Self / Parent-Guardian / Name of Organisation)

_____

_____

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Communication and Telehealth Consent

Do you consent to being contacted by (tick all that apply):

[ ] SMS [ ] Email [ ] Phone

Do you consent to appointment reminders by SMS/email? Yes / No

Do you consent to therapy sessions being conducted via secure Telehealth (e.g., Zoom)? Yes / No

Confidentiality and Information Sharing

Please note: Information you provide will remain confidential except where disclosure is required by law (e.g., risk of harm to self or others, child protection concerns, or court orders).

Do you consent to Mindswell Therapy, with your written authorisation, exchanging information with your GP or other health providers if required? Yes / No

Client Declaration

I confirm that the information provided in this form is accurate to the best of my knowledge. I understand how my information will be collected, stored, and protected under Mindswell Therapy's Privacy Policy. I acknowledge the limits to confidentiality as outlined above.

Client Name: _____ Signature: _____

Date: _____ / _____ / _____

Last reviewed: 06/09/2025 by Natalie Beach

Thank you for choosing Mindswell Therapy.

Therapy Done Differently.

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