ADULT INTAKE FORM FOR PSYCHOLOGICAL SERVICES

Thank you for taking the time to complete and sign this document.

1. YOUR DETAILS

First Name: _____ **Surname:** _____ **Date of birth:** _____

Years of education completed: _____ **Highest level of education:** _____

BRIEFY DESCRIBE YOUR REASON/S FOR SEEKING PSYCHOLOGICAL SUPPORT NOW

_____

_____

_____

_____

_____

2. CURRENT SYMPTOMS CHECKLIST

Current Symptoms	Please Circle	If Yes, when did the symptom first occur?	Current Symptoms	Please Circle	If Yes, when did the symptom first occur?
Depressed or low mood	**Yes/No**		Racing thoughts	**Yes/No**	
Loss of enjoyment or interest in previously enjoyed activities	**Yes/No**		Increased irritability	**Yes/No**	
Change in appetite	**Yes/No**		Increased risky behaviour	**Yes/No**	
Increase/decrease in libido	**Yes/No**		Impulsivity	**Yes/No**	
Fatigue	**Yes/No**		Excessive energy	**Yes/No**	
Crying spells	**Yes/No**		Decreased need for sleep	**Yes/No**	
Difficulty falling or staying asleep	**Yes/No**		Difficulties concentrating	**Yes/No**	
Increased worrying	**Yes/No**		Forgetfulness	**Yes/No**	
Anxiety attacks	**Yes/No**		Suspiciousness	**Yes/No**	
Avoidance	**Yes/No**		Hallucinations	**Yes/No**	
Intrusive thoughts	**Yes/No**		Excessive guilt	**Yes/No**	

3. CURRENT HOUSEHOLD AND FAMILY INFORMATION

Family Member's First and Last Name	Relationship to you (parent, spouse, partner, child, sibling, etc)	Age	Sex	Relationship Type (biological, step,etc)	Living with you? Y/N

4. PSYCHOLOGICAL/PSYCHIATRIC HISTORY

Mental health diagnosis (if any) _____

Previous Therapy (if any)

Name of provider of psychological therapy	Reason for seeking psychological support	What did you find most helpful in therapy?	What did you find least helpful in therapy?	Approximate dates of therapy commencement and discharge

FAMILY MEMBERS' PSYCHOLOGICAL/PSYCHIATRIC HISTORY, WHETHER DIAGNOSED OR NOT

Please tick if applicable

	Mother's side	Father's side	Siblings		Mother's side	Father's side	Siblings
Anxiety				Psychosis			
Depression				Schizophrenia			
Bipolar				Learning Disorder			
Addiction				Intellectual Impairment			
Obsessive/ Compulsive Disorder				Attempted/Completed Suicide			
Other: (please describe):							

5. DIFFICUTIES PAST OR PRESENT THAT MAY BE IMPACTING ON YOUR CURRENT WELLBEING

	Please Circle	If Yes, please describe
Complications in your mother's pregnancy with you?	Yes/No	
Birth complications?	Yes/No	
Delays in meeting your developmental milestones?	Yes/No	
Loss of consciousness at any age?	Yes/No	
Significant difficulties at any of the following stages:		
• Early childhood?	Yes/No	
• Kindergarten/Prep?	Yes/No	
• Primary School?	Yes/No	
• High School?	Yes/No	
• University/Tertiary Education?	Yes/No	
Difficulties in past or current romantic relationships?	Yes/No	
Difficulties in past or current occupations?	Yes/No	
Exposure to domestic violence/abuse?	Yes/No	
Concerns about vision or hearing?	Yes/No	
Medical condition/s or Medication?	Yes/No	
Concerns about use of alcohol, tobacco and/or illicit drugs?	Yes/No	

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Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you ***over the past week***. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0 Did not apply to me at all
1 Applied to me to some degree, or some of the time
2 Applied to me to a considerable degree, or a good part of time
3 Applied to me very much, or most of the time

1	I found it hard to wind down	0	1	2	3
2	I was aware of dryness of my mouth	0	1	2	3
3	I couldn't seem to experience any positive feeling at all	0	1	2	3
4	I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5	I found it difficult to work up the initiative to do things	0	1	2	3
6	I tended to over-react to situations	0	1	2	3
7	I experienced trembling (eg, in the hands)	0	1	2	3
8	I felt that I was using a lot of nervous energy	0	1	2	3
9	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
10	I felt that I had nothing to look forward to	0	1	2	3
11	I found myself getting agitated	0	1	2	3
12	I found it difficult to relax	0	1	2	3
13	I felt down-hearted and blue	0	1	2	3
14	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15	I felt I was close to panic	0	1	2	3
16	I was unable to become enthusiastic about anything	0	1	2	3
17	I felt I wasn't worth much as a person	0	1	2	3
18	I felt that I was rather touchy	0	1	2	3
19	I was aware of the action of my heart in the absence of physical exertion (e.g., sense of heart rate increase, heart missing a beat)	0	1	2	3
20	I felt scared without any good reason	0	1	2	3
21	I felt that life was meaningless	0	1	2	3

PAYMENT POLICY

Payment for psychology appointments with Dr Jayne Orr is required on the day of the consultation. If you have a valid Mental Health Care Plan (MHCP) or private health insurance, you may be eligible for a rebate towards this fee. For patients with a valid MHCP, Medicare claims will be submitted on your behalf by iHealth Centre on payment of your account. Alternatively, if you have private health insurance, our reception team will provide you with a receipt that you can lodge with your health insurer.

IF ANOTHER PERSON WILL BE PAYING YOUR ACCOUNT ON YOUR BEHALF

We require signed consent to contact this person, and the person must be aware that payment on the day of your appointment is required. Please complete what follows:

I _____ [patient full name], date of birth ___/___/_____ confirm that the following person will be paying for my appointments with Dr Jayne Orr and consent to iHealth Centre contacting this person in relation to any accounts outstanding:

Name of person paying account	Their telephone number	Their email address

APPOINTMENT REMINDERS AND CANCELLATION POLICY

- You will receive an SMS reminder 48 hours before your appointment. If you do not confirm your appointment by replying "Y" to the reminder SMS, our reception staff will phone you to obtain verbal confirmation.
- Dr Orr often has wait-listed patients. If you need to cancel or reschedule an appointment, please provide iHealth Centre with at least 24 hours' notice by telephone in standard working hours so that your appointment time can be offered to another patient. Please do not use email to cancel appointments because emails are not checked regularly.
- Cancellations within 24 hours will incur a non-rebatable full-session fee because three people are adversely impacted when patients do not attend scheduled sessions or do not give at least 24 hours' notice of cancellation: the patient, as therapeutic gains are less likely without adherence to the treatment plan; the patients on the wait-list who miss out on an appointment that has become available; and Dr Orr who has prepared for the session.
- Please note that further appointments will not be offered until outstanding fees have been paid.

LATE ARRIVAL FOR APPOINTMENTS POLICY

We understand that there are times when people arrive late for appointments. Please note that your appointment will still need to finish on time, and that the full appointment fee will be charged.

CONFIDENTIALITY POLICY

Dr Jayne Orr is bound by the Australian Psychological Society's Code of Ethics regarding confidentiality (Section A.5.2), as adopted by the Psychology Board of Australia. This states that client confidentiality must be maintained with the specific exceptions related to duty of care and legal obligation. This means that psychological therapy remains confidential unless permission is granted by the patient to discuss information disclosed during therapy sessions. Information pertaining to your diagnosis, treatment suggestions and progress made towards treatment goals will be provided to your referring medical practitioner. All personal information gathered by Dr Orr during the provision of the psychological service will not be disclosed except:

1. when it is subpoenaed by a court; or
2. when failure to disclose the information would, in the reasonable belief of Dr Orr, place you or another person at serious risk to life, health or safety; or
3. your prior approval has been obtained to
   a) provide a written report to another professional or agency. e.g., a lawyer; or
   b) discuss the material with another person, e.g., an Allied Health Professional; or
   c) disclose the information in another way; or
4. disclosure is otherwise required by law.

CONSENT

I understand that signing in the designated area below confirms that the information I have provided is correct, and I agree to the permissions and policies contained in this document as part of the service provided by Dr Jayne Orr.

Patient's first and last name: _____

Signature: _____ **Date:** _____