

Ghita Andersen: Counselling, NLP & Family Mediation – **Client Intake Form**

Please complete all the information relevant to you. Today’s Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact / Spouses Name & Ph:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GP’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about Ghita Therapy?

|  |  |
| --- | --- |
| * Google Ads
 | * Friend
 |
| * Google Search or Maps
 | * Doctor Referral
 |

Have you ever tried Counselling, Psychotherapy, Mediation or Couples Therapy before? ( ) Yes ( ) No

If yes, did it help you? ( ) Yes ( ) No What kind of therapy?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What did you see them for? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you seeing anyone now?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are the main problem(s) for which you are seeking help?

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there anything important (relating to your problems) that you think your therapist should know asap?

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Does Ghita have your permission to try various counselling methods to heal you? For example:

Are you willing to lower your defenses to get to the heart of your problems and to express your true emotions?

( ) Yes ( ) No

Are you willing to listen, take constructive advice and commit to the work (exercises) and any counselling homework that your professional believes will help you to heal?

( ) Yes ( ) No

CLIENT HISTORY:

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupational History: Are you currently: ( ) Working ( ) Student ( ) Unemployed ( ) Disabled ( ) Retired

Current Symptoms Checklist: Please circle or tick if any of the following symptoms are present:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Depressed mood  | Excessive worrying  | Concentration issues  | Negative thoughts Self-defeating | Panic attacks  |
| Perfectionism/Judgement | Yelling often  | Crying spells | General not coping  | Post-natal issues |
| Forgetting things  | Risky behaviours  | Compulsions | Laziness or Fatigue  | Insomnia/ Sleep  |
| Eating too much/Eating too little  | Loss of interest in normal activities  | Easy to Anger  | Constantly stressed / Anxious  | Resentment |
| Avoidance of social outings  | Suspiciousness/Paranoia  | Smoking | Increased Gambling  | Mistrust of Friends/ Family/ Partner  |
| Excessive Exercise  | Decreased libido  | Excessive libido  | Money worries | Fearful of future |
| Feeling like victim | Feeling bullied | Feeling vulnerable | Feeling guilty  | Feeling unlovable |

Suicide Risk Assessment

Do you sometimes feel hopeless and/ or worthless? ( ) Yes ( ) No.

Have you ever had feelings or thoughts that you didn't want to live? ( ) Yes ( ) No.

Do you currently feel that you don't want to live? ( ) Yes ( ) No

When was the last time you had thoughts of dying? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship History and Current Family:

Are you currently: ( ) Single ( ) Married ( ) Living Together ( ) In Relationship ( ) Divorced ( ) Widowed

How long?\_\_\_\_\_\_\_\_\_\_\_\_ Are you sexually active? ( ) Yes ( ) No

Couples: Describe your relationship with your spouse or partner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Couples: On a scale from 1 - 10 how committed are you to this relationship? 1, 2, 3, 4, 5, 6, 7, 8, 9, 10

Couples: Do you have thoughts or plans about leaving this relationship and separating? ( ) Yes ( ) No

Is there any family violence occurring? (Domestic abuse or partner violence and can take many forms: It can be physical violence or verbal abuse, or subtle and controlling – such as emotional, financial manipulation.)

( ) Yes ( ) No. If yes, what happens and how often does this occur?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you been married before? ( ) Yes ( ) No. How many times? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have children? ( ) Yes ( ) No How many? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are their names?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Describe your relationship with your children: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Personal and Family Medical History:

Sexual Orientation: ( ) straight/ heterosexual ( ) lesbian/ homosexual ( ) bisexual ( ) transsexual

What do you do to relax and unwind? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you exercise regularly? ( ) Yes ( ) No How many times a week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What kind of exercise do? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications:

Have you ever taken any of the following medications?: Anti-depressants, Mood stabilisers, Anti-psychotics

Which and when?:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Psychiatric History:

Has anyone in your family (including you) been diagnosed with the following: Please circle:

|  |  |  |  |
| --- | --- | --- | --- |
| Bipolar Disorder | Anxiety (GAD) | Depression (MDD, Post-Partum) | Alcoholism |
| Schizophrenia | Substance abuse | Post Traumatic Stress (PTSD) | Suicide Attempt  |

If yes, who had the problem?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Substance Use:

Do you have a problem with alcohol? ( ) Yes ( ) No How often do you drink alcohol? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been treated for alcohol, or drug use? ( ) Yes ( ) No

Any recreational drugs/ steroids? ( ) Yes ( ) No If yes, which drugs?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many caffeinated beverages do you drink a day?

Coffee \_\_\_\_\_\_\_ Soda \_\_\_\_\_\_\_\_ Tea \_\_\_\_\_\_\_\_\_ Energy Drinks \_\_\_\_\_\_\_\_\_

Tobacco: Current Smoker? ( ) Yes ( ) No Past Smoker? ( ) Yes ( ) No

How many packs per day on average? \_\_\_\_\_\_\_\_\_\_\_\_\_ How many years? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Background and Childhood History:

How many brothers/ sisters do you have?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Were you adopted? ( ) Yes ( ) No

Where did you grow up? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What position do you hold in the family? (Oldest, youngest) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did your parents' divorce? ( ) Yes ( ) No If so, how old were you when they divorced? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

If your parents divorced, who did you live with?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father: Describe your relationship with your dad: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Mother: Describe your relationship with your mum: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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How old were you when you left home? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has anyone in your immediate family died? Who and when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Trauma History:

Have you ever been abused?: Verbally, physically, sexually or by parent neglect? ( ) Yes ( ) No.

Please describe when, where and by whom: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**PLEASE READ BEFORE SIGNING**

**24 HOUR CANCELLATION POLICY: Short Notice Cancellations and No Shows**

Cancellation (less than 24 hours notice) and No Shows are charged at minimum ONE HOUR FEE because:

* Appointments cannot be filled at short notice. (Sickness or family problems are not exceptions)
* Standard Industry policy: Most psychologists insist on 48 hours
* Other clients may have been turned away for your time slot
* 24 Hour Policy is stated in booking SMSandstated on this contract which clients have read and signed
* ​Therapy fees will be deducted from prepaid amounts or billed to you via email
* Ghita Therapy does not offer refunds after clients have confirmed their 24 hour reminder: *http://www.ghitaandersen.com/cancellation-policy.html*

**Confidentialty: Confidentiality** is maintained for clients as far as possible. However, when a person is believed to be at risk of serious harm, or admits to harming another or planning a criminal offence, confidentiality must be waived under a duty of care (Qld Mandatory Reporting). Furthermore, I can read about my rights and data storage online at: *http://www.ghitaandersen.com/client-confidentiality.html*

I have read and agree to the 24 Hour Cancellation Policy terms and Confidentiality Clause above. I understand that as a client I have the right to be treated ethically as stipulated by professional ethical guidelines.

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_