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|  | **Confidential Basic Information** | | | | | | | | | | | | |  | | | | |
| Date: |  | | | | | | | | | | | | |  | | | | |
| Name:  (Mr, Mrs, Ms, Miss, Mx) |  | | | | | | | | | | | | | | | | | |
| Address: |  | | | | | | | | | | | | | | | | | |
| Phone: | Mob: | | | | | | | Home/Work: | | | | | | | | | | |
| Email: |  | | | | | | | | | | | Would you like to be added to our mailing list?  Yes  No | | | | | | |
| Date of Birth: |  | | | | | | | Gender: (optional) | | | | | | | | | | |
| Medicare Number:  (10 digits): |  | | | | | | Number on Card: | | | | | | | | Expiry Date: | | | |
| Mental Health Treatment Plan: | Date of Referral: | | | | | | | | | | | Doctor: | | | | | | |
| Employed: Yes/No | If Yes, employed as:  If No, please check: Retired / Student / Unemployed | | | | | | | | | | | | | | | | | |
| Marital Status  (please check): | Never Married | Partner | | | Married | | | Separated | | | Divorced | | | | | Widowed | | Minor |
| If you would like to be identified as either of these, please check: (Optional) | Aboriginal/Torres Strait Islander | | | | | | | Cultural and Linguistic Different (please identify your culture) | | | | | | | | | | |
| Spiritual Affiliation/Belief: |  | | | | | | | | | | | | | | | | | |
| What is the main problem that brought you here? (please check) | Stress | | | Anxiety | | | | | Depression | | | | | | | | Anger | |
| Grief & Loss | | | Trauma | | | | | Relationship/Family | | | | | | | | Work/School | |
| Bullying/harassment | | | Illness (your own or someone else) | | | | | Addiction | | | | | | | | Other: | |
| Are you currently taking any medication? Please list. |  | | | | | | | | | | | | | | | | | |
| Do you have any medical or mental health diagnoses? |  | | | | | | | | | | | | | | | | | |
| How did you hear about this practice? |  | | | | | | | | | | | | | | | | | |
| Preferred payment method (please check): | Bulk bill (only available with MHTP) | | | | | | | Private Payment (cash or bank deposit only) | | | | | | | | | | |
| Private Health Insurance | | | | | | | Invoice from organisation | | | | | | | | | | |
| Emergency Contact: | Name: | | | | | Phone: | | | | | | | Relationship: | | | | | |
| I would like to be notified of appointments via: | | | Text | | | | | | | Phone call | | | | | | | | |