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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 |