

**CONFIDENTIAL CLIENT HISTORY**

Name \_\_\_\_\_  
Address \_\_\_\_\_ Suburb \_\_\_\_\_ Postcode \_\_\_\_\_  
DOB \_\_\_\_\_ Age \_\_\_\_\_ Guardian Name \_\_\_\_\_  
Phone H \_\_\_\_\_ W \_\_\_\_\_ M \_\_\_\_\_  
Medicare Number \_\_\_\_\_ Card Reference Number \_\_\_\_\_ Middle Initial \_\_\_\_\_

Family GP \_\_\_\_\_ Other Health Professional \_\_\_\_\_  
Employment Position \_\_\_\_\_ Employment Status \_\_\_\_ FT \_\_\_\_ PT \_\_\_\_ Casual  
Religion/Spiritual Belief \_\_\_\_\_ Guardian Relationship \_\_\_\_\_  
Names, Ages and Relationship to Family Members \_\_\_\_\_  
What language do you speak at home \_\_\_\_\_ Do you require an interpreter \_\_\_\_\_

Please State Briefly the Reason for Your Visit Today \_\_\_\_\_  
\_\_\_\_\_

Have You Previously Consulted a Psychologist (incl. date, reason) \_\_\_\_\_  
\_\_\_\_\_

Are You Aware of a Family History of Psychological/Physical Difficulties \_\_\_\_\_  
\_\_\_\_\_

Current Medications and/or Supplements \_\_\_\_\_  
\_\_\_\_\_

Please Describe Past Trauma/Accidents (incl. date, age) \_\_\_\_\_  
\_\_\_\_\_

Past Surgery/Hospitalisation Details \_\_\_\_\_  
\_\_\_\_\_

Childhood and Other Illness \_\_\_\_\_  
\_\_\_\_\_

Please Provide Details of Your Birth (incl. time of day, duration of labour, any complications) \_\_\_\_\_  
\_\_\_\_\_



Please indicate by ticking the relevant box the degree to which any of the below may apply to you. If a particular issue does not apply to you then please leave the boxes blank. (1 = mild; 2 = moderate; 3 = severe)

1 2 3

- phobias
- obsessions
- nightmares
- migraines
- anxiety
- depression
- chronic pain
- stress
- alcohol use
- difficulty sleeping
- overeating
- skin disorder
- nervous twitching
- memory loss
- drug use
- emotional abuse
- irritability
- nail biting

1 2 3

- panic attacks
- dyslexia
- epilepsy
- loss of control
- under eating
- physical abuse
- sexual abuse
- fears
- negative thinking
- over sleeping
- difficulty concentrating
- paranoid thinking
- hearing voices
- visual hallucinations
- sexual problems
- over active thinking
- learning difficulties
- chronic tiredness/lethargy

What Are Your Current Hobbies/Interests \_\_\_\_\_

Do You Currently Drink Alcohol (incl. frequency, quantity) \_\_\_\_\_

Do You Currently Use Non Prescription Drugs (incl. frequency, quantity) \_\_\_\_\_

Have You Ever Been Hypnotised \_\_\_\_\_

Were You Referred by Your GP (if not please inform how you were advised of our services) \_\_\_\_\_

Are You a Health Care Card Holder \_\_\_\_\_

### **CANCELLATION POLICY**

The cost of a consultation (*usually around "50" minutes in duration*) is \$180, which is payable on the day of the appointment – no accounts are given. If, for some reason you need to cancel or postpone the appointment, you are required to give at least 48 hours notice. Cancellations of 24-48 hours notice incur a charge of 50% of the psychological consultation fee. Cancellations of less than 24 hours notice incur a charge of 100% of the psychological consultation fee. For appointments that are scheduled on a Monday, please note that advice of inability to attend is required to be provided on the preceding Friday – advice of cancellation provided over the weekend will not be accepted. Additionally, please be aware that a Medicare rebate is not available for cancelled appointments which incur a cancellation fee. Please refer to the Information and Consent Form for further details of the Cancellation Policy.

I have read and accept David Younger Psychology's cancellation policy. I request psychological assistance.

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