

Welcome to Body & Brain Centre!

Please note: information provided on this form is protected as confidential information.

Name: _____ DOB: _____ Age: _____

Parent / Legal Guardian (if under 18): _____

Address: _____ Suburb: _____ Postcode: _____

Phone: _____ May we leave a message? Yes No

Mobile: _____ May we leave a message? Yes No

Email Address: _____ May we leave a message? Yes No

Please note that email correspondence is not considered to be a confidential medium of communication.

Please Tick: I would like to receive newsletters with special offers, health tips and more.

Marital Status: _____ Partner's Name: _____

Children Names & Ages: _____

Who can we thank for referring you? _____ PS they will get a thank-you voucher

If online, what search words were used? _____

History

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc)? Yes No Previous therapist: _____

Are you currently taking any prescription medication? Yes No If yes, please list:

Have you ever been prescribed psychiatric medication? Yes No If yes, please list & provide dates taken:

General & Mental Health Information

For the following questions use a scale of 1 - 10 with 1 being poor & 10 being exceptional.

How would you rate your current physical health? ___/10

Please list any specific health problems you are currently experiencing:

How would you rate your current sleeping habits? ___/10

Trouble getting to sleep Wake up in the night Awake Feeling: Tired Alert

Please list any specific sleep problems you are currently experiencing:

Exercise ___/10

Typical exercise routine:

Type: _____ Intensity / Distance: _____ Frequency: ___ per week

Type: _____ Intensity / Distance: _____ Frequency: ___ per week

Physical

Chiropractic
Myotherapy
Remedial Massage

Brain

Biofeedback
Neuro-Rehab
Brain Scans

Emotional

Counselling
Meditation

Nutritional

Dietetics/Nutrition
Naturopathy

Traditional

Acupuncture
Chinese Medicine

Please list any difficulties you experience with your appetite or eating problems:

Are you currently experiencing overwhelming sadness, grief or depression? Yes No
If yes, for approximately how long? _____

Are you currently experiencing anxiety, panic attacks or have any phobias? Yes No
If yes, when did you begin experiencing this? _____

Are you currently experiencing any chronic pain? Yes No
If yes, please describe: _____

Do you drink alcohol more than once a week? Yes No

How often do you engage in recreational drug use?
 Daily Weekly Monthly Infrequently Never

Are you currently in a romantic relationship? Yes No If yes, how long? _____

How would you rate your romantic relationship? ____/10

What significant life changes or stressful events have you experienced recently?

Family Mental Health History

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (eg: father, grandmother, uncle, etc)

	Yes	No	Family member's relationship to you (eg: father, grandmother)
Alcohol / Substance Abuse			
Anxiety			
Depression			
Domestic Violence			
Eating disorders			
Obesity			
Obsessive Compulsive behaviour			
Schizophrenia			
Suicide Attempts			

Additional Information

Are you currently employed? Yes No
If yes, what is your current employment situation?

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Do you enjoy your work? Is there anything stressful about your current work?

Do you consider yourself to be spiritual or religious? Yes No

If yes, please describe your faith or belief:

What do you consider to be some of your strengths?

What do you consider to be some of your weaknesses?

What would you like to accomplish out of your time in therapy?

By looking at the following aspects of your life, write down all the things that come to mind for each area:

Home / environment	Health (physical & mental)
Family	Love & sexuality

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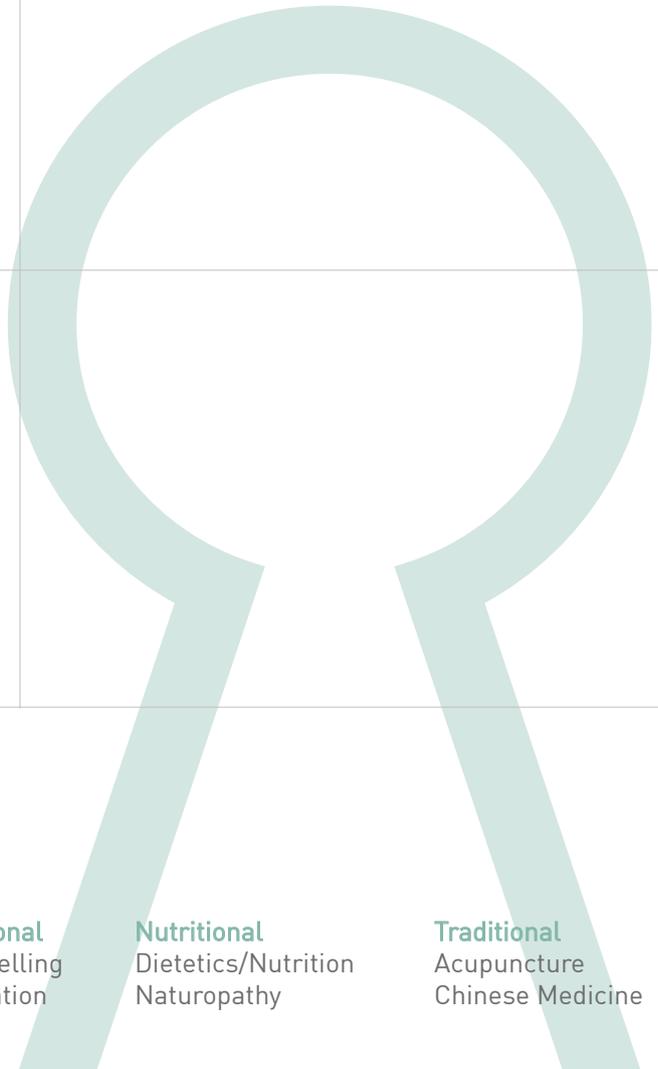
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Money & finances	Career and work / life purpose
Relationships / friendships	Community
Leisure & fun	Creativity
Spirituality	



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Confidentiality

What you discuss during your therapy session is kept confidential. No contents of the therapy sessions, whether verbal or written may be shared with another party without your written consent or the written consent of your legal guardian.

The following is a list of exceptions: Duty to warn and protect

- If you disclose a plan or threat to harm yourself, the therapist must attempt to notify your family and notify legal authorities. In addition, if you disclose a plan to threat or harm another person, the therapist is required to warn the possible victim and notify legal authorities.
- Abuse of children or vulnerable adults: if you disclose, or it is suspected, that there is abuse or harmful neglect of children or vulnerable adults (ie: the elderly, disabled / incompetent), the therapist must report this information to the appropriate state agency and / or legal authorities.
- A court order, issued by a judge, may require the Counselling Services staff to release information contained in records and/or require a therapist to testify in a court hearing.

Consent to Therapy

Counselling is a confidential process designed to help you address your concerns, come to a greater understanding of yourself, and learn effective personal and interpersonal coping strategies. It involves a relationship between you and a trained therapist who has the desire and willingness to help you accomplish your individual goals.

Counselling involves sharing sensitive, personal, and private information that may at times be distressing. During the course of counselling, there may be periods of increased anxiety or confusion and there are risks of experiencing uncomfortable feelings, such as sadness, guilt, anger, frustration, loneliness and helplessness, because the process of Counselling often requires discussing the unpleasant aspects of your life.

The outcome of counselling is often positive; with many people experiencing:

- ***A significant reduction in feelings of distress;***
- ***Increased satisfaction in interpersonal relationships;***
- ***Greater personal awareness and insight;***
- ***Increased skills for managing stress; and***
- ***Resolutions to specific problems.***

However, the level of satisfaction for any individual is not predictable. Your therapist is available to support you throughout the counselling process.

Risks associated with not seeking treatment are a possible increase in the above symptoms. Additionally there are other treatment options available such as medications which carry their own risks including toxicity / overdose and organ damage.

Research

Research studies and presentations are performed from time to time within BBC. This assists us deliver the best quality care and to educate fellow practitioners. All identifying information is removed and your involvement doesn't change your management plan. Participation is voluntary and consent may be revoked at any time. There are no additional risks associated with being involved in BBC collecting your de-identified clinical information.

PLEASE DO NOT SIGN UNTIL YOU HAVE SPOKEN TO YOUR COUNSELLOR.

I have had the opportunity to discuss with the counsellor and ask questions about the nature and purpose of the proposed therapy and all of my concerns. I understand that results are not guaranteed.

Please Tick

- The information provided is accurate and fully inclusive to the best of my knowledge. I understand the advice and management plan is made on the information that I provide. I will update my practitioner on any medical conditions or health concerns as they arise.
- I hereby request and consent to counselling management. I understand that I can withdraw my consent at any time.
- I hereby consent for my de-identified information to be used in research and presentations and BBC.

- I understand I must provide 24 hours notice if I'm unable to attend my scheduled appointment to avoid paying a 50% late fee. If I fail to attend an appointment, without notice, I understand I'm liable for 100% of the consultation fees. I also understand that fees are payable on the day of consultation.

SIGNATURE _____

DATE _____

PRINT NAME _____
(Parent/Guardian if under 18 years)

COUNSELLORS' SIGNATURE _____

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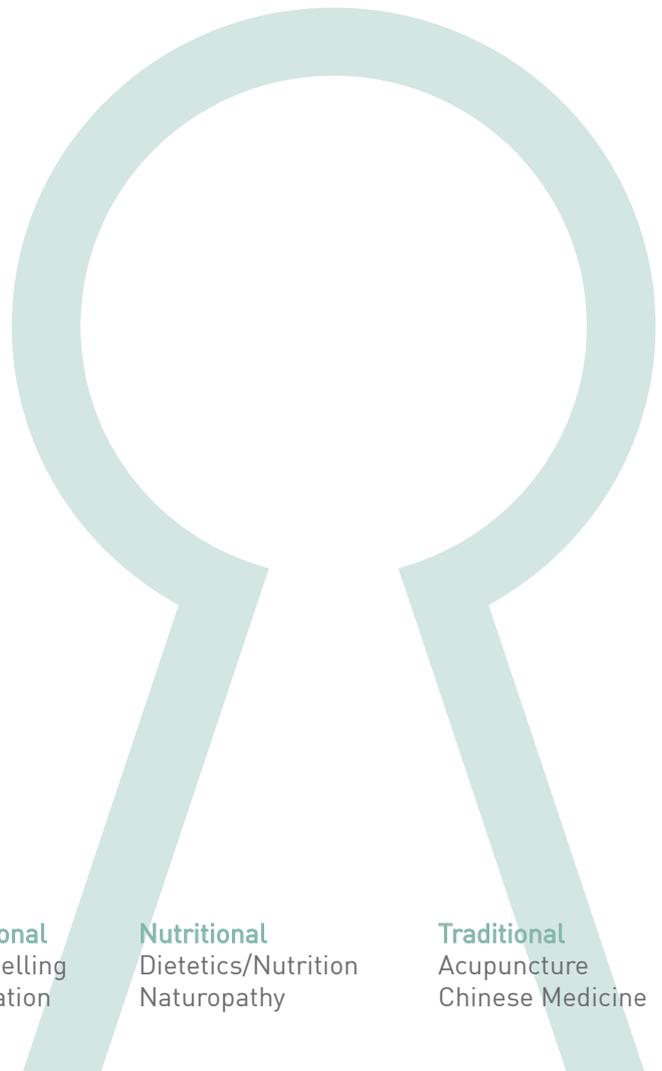
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