FUTURE 4U
CLIENT CONTACT FORM

Information supplied on this form is confidential and will be safeguarded under the guidelines of the Privacy Act. Please supply us accurate information as your individual therapy plan depends on the information supplied.

Name of client: ______________________ Date of Birth: ______________________

Gender: ______________________ Marital status: ______________________

Address: ______________________

______________________ Ethnic group: ______________________

______________________ NHI number: ______________________

Mobile : ______________________ May we leave a message? Yes or No

Other phone: ______________________

E-mail: ______________________ May we e-mail you? Yes or No

Dependants: ______________________ Age: ______________________

______________________ Age: ______________________

______________________ Age: ______________________

Next of kin: ______________________ Phone: ______________________

Address: ______________________

GP: ______________________ Phone: ______________________

1. Are you taking any prescribed medication? Yes / No
2. If yes list the names of the medication please ______________________
3. Have you ever been prescribed psychiatric medication? Yes / No
4. If yes list the names of the medication please: ______________________
5. Have you ever received any type of mental health services? Yes / No
6. If yes please give details: ______________________
7. How many times a week do you exercise? ______________________
8. What type of exercise do you participate in? ______________________
9. Please rate your current medical health? Poor 1 2 3 4 5 Excellent ____________
10. Any specific problems? ______________________
11. How well do you sleep? Poor 1 2 3 4 5 Excellent ____________
12. Any specific problems? ______________________
13. Are you currently experiencing significant: Sadness Grief Depression
14. When did you start experiencing this? ______________________
15. Are you currently experiencing significant: Anxiety Phobias Panic Attacks

16. When did you start experiencing this?

17. Are you experiencing chronic pain?

18. Have you experienced any significant life changing or stressful events recently?

19. Are you currently employed?

20. What is your current position?

21. Do you enjoy your work?

22. Is your work stressful? If yes what?

23. Do you consider yourself religious or spiritual?

24. Define your faith or belief?

25. What are some of your strengths?

26. What are some of your weaknesses?

27. What are your goals from therapy?

28. Please indicate if you have a family history of any of the following, and indicate the relationship with you, for example father, sister etc.

28.1.	Alcohol /substance abuse	Yes / No	
28.2.	Anxiety	Yes / No	
28.3.	Depression	Yes / No	
28.4.	Domestic Violence	Yes / No	
28.5.	Eating disorders	Yes / No	
28.6.	Obesity	Yes / No	
28.7.	Obsessive compulsive behaviour	Yes / No	
28.8.	Schizophrenia	Yes / No	
28.9.	Suicide / suicide attempts	Yes / No	

Thank you for giving us this very personal information. We will treat it with the utmost respect.