Client Intake Form

ALT WORKSPACE

PERSONAL DETAILS:

Full Legal Name:

Preferred name:

Age: _____ Date of Birth:_____

Address:

Relationship Status: Occupation:

Email address: Telephone:

Emergency contact name and telephone number:

HEALTH:

Doctor's name and address:

Date of last check up:

Current Medications and/or Supplements :

Health Challenges (past & current):

From the list below CIRCLE/TICK any areas of concern that apply:

Addictions Drinking Smoking Drugs Gambling Compulsive Behaviour	Driving Skills	Anxiety Stress Fears Phobias Panic Attacks Guilt Relaxation	Eating Problems Food /Diet Weight Problems Anorexia Bulimia Exercise
Career Issues Interview Skills Nerves Public Speaking Concentration Exams Memory		Sexual Problems Fertility IVF Conception Pregnancy Birth	Pain Control Hearing Sight/Vision Mobility Skin Problems Hair Growth

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Depression

Confidence Self

Esteem Motivation

Achieving Goals

Procrastination

Relationships Childhood

Problems

Sleep Problems

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*** Completing this section is OPTIONAL - we will go through these questions in your session.

INTAKE	NOTES
STH Symptoms/ Triggers/ Habits:	
CH Childhood	
WYW What you Want / Magic Wand	
LWP Life Without the Problem	

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Please read the terms & conditions below:
(Indicate in the checkbox to agree to optional items)

As part of providing a mental health / therapeutic service to you, we will need to collect, record & retain certain personal information relevant to your case. You may view and/or request a copy of this information at any stage in writing from your practitioner (an administrative fee may be incurred).

All such information will remain confidential and will not be released without written consent or permission except where it is subpoenaed by a court or required by law.
(You may also elect sign a separate authority to disclose so information can be shared with your other treating practitioners).

☐ I would be happy to provide a testimonial (either written or video)
I understand that any feedback given may be posted online or on our website, and can request that it be removed at any time.
(tick the box or Type YES)

I confirm that the information provided above is correct & true to the best of my knowledge

☐ (tick the box or Type YES)

(Type Your Full Name) (Todays Date)

(Signature – OR type your name & email)

Once completed & signed please email to: info@altworkspace.com
If you do not receive confirmation your email has been received within 24 hours – please resend and or SMS Renee on 0466 90 2460.

There is a preference to complete manually & email due to privacy concerns.