CLIENT INTAKE FORM

Please provide the following information. Leave blank any question you would rather not answer or would prefer to discuss with your clinical psychologist.

DO NOT USE YOUR NAME. CHOOSE A RANDOM PASSWORD THAT CAN LATER BE USED TO IDENTIFY YOU:_____

Please email this form to info@autismassessments.com.au

PRIMARY CONCERN

Please share why you're seeking an assessment at this time:

_____
_____
_____

If you are currently in distress, how long has this been going on?

_____
_____

Is this concern related to a known mental health diagnosis, like depression or anxiety?
( ) no ( ) yes ( ) N/A- no mental health diagnosis

TREATMENT HISTORY

Are you currently receiving psychiatric services, professional counselling or psychotherapy elsewhere? ( ) yes ( ) no

Have you had previous psychotherapy?
( ) no
( ) yes

Are you currently taking prescribed psychiatric medication (antidepressants or others)? ( ) yes ( ) no

If yes, please list: _____

Prescribed by: _____

HEALTH AND SOCIAL INFORMATION

Are you currently seeing more than one medical health specialist? ( ) yes ( ) no

If yes, please list: _____

When was your last physical examination? _____

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.:
_____
_____

Are you currently on medication to manage a physical health concern? If yes, please list: _____
_____

Are you having any problems with your sleep habits? ( ) yes ( ) no

If yes, check where applicable:
( ) Sleeping too little ( ) Sleeping too much ( ) Poor quality sleep
( ) Disturbing dreams ( ) other _____

How many times per week do you exercise? _____

Approximately how long each time? _____

Are you having any difficulty with appetite or eating habits? ( ) no ( ) yes

If yes, check where applicable: ( ) Eating less ( ) Eating more ( ) Bingeing
( ) Restricting

Have you experienced significant weight change in the last 2 months? ( ) no ( ) yes

Do you regularly use alcohol? ( ) no ( ) yes

In a typical month, how often do you have 4 or more drinks in a 24 hour period?

_____

How often do you engage recreational drug use? ( ) daily ( ) weekly ( ) monthly
( ) rarely ( ) never

Do you smoke cigarettes or use other tobacco products? ( ) yes ( ) no

Have you had suicidal thoughts recently?
( ) frequently ( ) sometimes ( ) rarely ( ) never

Have you had them in the past?
( ) frequently ( ) sometimes ( ) rarely ( ) never

In the last year, have you experienced any significant life changes or stressors? If yes, please explain: _____

_____

Have you ever experienced any of the following?

Extreme depressed mood	Yes / No
Dramatic mood swings	Yes / No
Rapid speech	Yes / No
Extreme anxiety	Yes / No
Panic attacks	Yes / No
Phobias	Yes / No
Sleep disturbances	Yes / No
Hallucinations	Yes / No
Unexplained losses of time	Yes / No
Unexplained memory lapses	Yes / No
Alcohol/substance abuse	Yes / No
Frequent body complaints	Yes / No
Eating disorder	Yes / No
Body image problems	Yes / No
Repetitive thoughts (e.g. obsessions)	Yes / No
Repetitive behaviors (e.g. frequent checking, hand washing	Yes / No
Homicidal thoughts	Yes / No
Suicidal attempts	Yes / No If yes, when?

OCCUPATIONAL INFORMATION

Please list any work-related stressors, if any _____

_____

_____

Are you currently in school? ( ) no ( ) yes

If yes, please share. _____

FAMILY MENTAL HEALTH HISTORY

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g. sibling parent, uncle, etc.)

Difficulty	**Yes / No**	**Family member**
Depression	Yes / No	
Bipolar disorder	Yes / No	
Anxiety disorder	Yes / No	
Panic attacks	Yes / No	
Schizophrenia	Yes / No	
Alcohol/substance abuse	Yes / No	
Eating disorders	Yes / No	
Learning disabilities	Yes / No	
Trauma history	Yes / No	
Suicide attempts	Yes / No	
Chronic illness	Yes / No	