Thinkshift
TRANSFORMING LIVES

Psychotherapy, Hypnotherapy & Counselling

Personal History Questionnaire REF (_____-_____-_____)

Name ..... **Birth Date** ..... /..... / ..... **Age** .....

Address ..... **Suburb** ..... **Post Code** .....

Home Tel # ..... **Mobile** .....

Email Address .....

Occupation .....

What hobbies or enjoyable pastimes do you have? .....

What are your skills and talents? .....

Emergency Contact Person ..... **Relationship** ..... **Mobile** .....

Do you suffer from any of the following conditions? *If so, please tick the appropriate ones, if in doubt tick anyway.*

Performance Anxiety		Obsession Compulsive		Headaches and Migraines		Addictive Behaviours		Other (please specify):	
Anxiety		Depression		Repetitive Thoughts		Drug Dependence		Digestive Issues	
Panic Attacks		Fatigue		Negative Thoughts		Substance Abuse		Diabetes	
Phobias		Insomnia		Low Blood Pressure		Eating Disorders		Indigestion	
Stress / Worry		Nightmares		High Blood Pressure		Chronic Pain		Irritable Bowel	

Have you been diagnosed with Dissociative Identity Disorder (Multiple Personalities)? Yes / No / Don't Know

Have you ever been diagnosed with Psychosis, Epilepsy or Schizophrenia? Yes / No / Don't Know

(Provide details if applicable) .....

Your GP's Name ..... **Practice Suburb** ..... **Tel #** .....

Your Current Medications? .....

Medications are for? .....

Have you experienced hypnosis? Yes / No **If so how long ago?** ..... **Performed By** .....

Have you ever experienced: meditation / yoga? Yes / No **Drug altered states?** Yes / No .....

Have you had psychological counselling? Yes / No **If so, which year/s?** .....

Name of Therapist ..... **Primary Purpose?** .....

Aspects of yourself / behaviour you wish to change through psychotherapy / hypnotherapy / counselling?

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Signature: ..... Date: .....

Thank you for completing this side, now please complete the second page

Office Use

Please acknowledge each box after reading and being aware of the contents of each clause:

☐ **Psychotherapy / Hypnotherapy / Counselling Services:**

In order to provide the best support possible to you, Thinkshift will need to collect and record personal information, manually and electronically, during each session. The information will be used to set goals and to monitor progress which may be relevant for future sessions. Paper information will be stored in a locked filing cabinet and electronic information under password protected software.

☐ **Access:**

You may access the material in your file with written request.

☐ **Confidentiality:**

All personal information gathered by the practitioners during the provision of the services will remain confidential and secure with the following exceptions:

(1) It is subpoenaed by a court of law,

(2) Failure to disclose the information would place you and or another person at risk,

(3) If your prior approval has been obtained to: provide a written report to another professional or agency, e.g. your GP / solicitor, or to discuss the material with another person, e.g. a partner, parent or employer.

(4) If your NDIS co-ordinator requires details of your progress and an estimate of the number of sessions you may require and other details in order to assess the continuity of service on your behalf.

(5) To ensure that you receive the best possible care, details of your case may be discussed with the practitioner's supervisor in confidential terms. During these discussions your identity will not be revealed.

☐ **Appointment Times and Fees:**

An initial consultation is 90 minutes and costs $225 and follow up sessions are 90 minutes and cost $225.

Fees are payable via credit card or bank transfer.

Banking details are: Acct Name: Thinkshift Pty Ltd | BSB: 063-527 | Acc#: 1095 9637 | Amount: $225 | Ref: Your family name.

Please note that cancellations require 24 hours cancellation notice, or they will incur a $150 cancellation fee.

☐ **Commitment to Professional and Ethical Conduct:**

Thinkshift Pty Ltd and Andrew Reay abide by the charters of the:

- Australian Counselling Association (ACA-8312-Level 4)
- Australian Association of Clinical Hypnotherapy and Psychotherapy (AACHP-2003094)
- Eye Movement Desensitization Reprocessing Association of Australia (EMDRAA#1001198)
- Havening and Brainspotting organisations.

Some of the key points are:

- You will receive a clear explanation of the service you will receive
- You will be treated with respect
- Your consent for any service will be sought prior to the service commencing and as it progresses
- You will receive an explanation about the nature and limits of confidentiality
- You will receive competent and professional service
- You will receive a clear statement about fees
- You will be clear about outcomes that you and Andrew Reay are working towards
- You will be shown respect for your cultural background, gender and religion

I, *(your name)* **…… , have read and understood the above consent form. I agree to these conditions for Psychotherapy, Counselling and Hypnotherapy provided by Thinkshift Pty Ltd.**

Signed: …… Date: ……. / …….. / 20 …….