

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

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?

How did you find out about us?

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 \$270 and follow up sessions are 60 minutes and cost \$180. **Fees are payable via credit card or bank transfer.** Card transactions attract a bank progressing fee of 1.15%.

Banking details are: Acct Name: Thinkshift Pty Ltd | BSB: 083-543 | Acc#: 292 194 571 | Amount: \$270 | Ref: Your family name.

Please note that cancellations require 24 hours cancellation notice, or they will incur a \$180 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)
- Havening and Brainspotting organisations
- Eye Movement Desensitization Reprocessing Association of Australia (EMDRAA#1001198)
- Psychotherapy and Counselling Federation of Australia, PACFA Reg. Clinical 30404

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