Open Arms Health – Client Intake Form

Where Compassion Meets Conversation

At Open Arms Health, I believe healing begins in a space where you feel heard, respected, and supported. This form helps me understand you and your needs so I can offer care that is compassionate, collaborative, and tailored to you.

Client Information

Full Name: _____

Preferred Name: _____

Date of Birth: ____ / ____ / _____

Age: _____ Gender (optional): _____

Pronouns (optional): _____

Phone Number: _____

Email Address: _____

Home Address: _____

Emergency Contact Name: _____

Relationship: _____ Phone: _____

Appointment & Referral Details (Including GP)

How did you hear about Open Arms Health?

☐ GP / Health Professional ☐ Website ☐ Social Media ☐ Friend/Family

☐ Other: _____

****Have you attended therapy or counselling before?** ☐ Yes ☐ No

If yes, please briefly describe (optional):

_____

Your Reasons for Seeking Support

What brings you to therapy at this time? (There is no right or wrong answer. Share only what feels comfortable for you.) (Please tick all that apply)

☐ Anxiety / Stress ☐ Depression / Low Mood ☐ Relationship Difficulties ☐ Couples or Family Conflict ☐ Communication Issues ☐ Self-esteem / Confidence ☐ Trauma / Past Experiences ☐ Life Transitions ☐ Grief or Loss ☐ Emotional Regulation ☐ Other: _____

Please describe your main concerns in your own words:

_____

_____

_____

Relationship & Family Background

Current Relationship Status: ☐ Single ☐ In a Relationship ☐ Married ☐ Separated ☐ Divorced

Are you attending: ☐ Individual Therapy ☐ Couples Therapy

If couples therapy, partner's name: _____

Children (if applicable – ages): _____

Your Emotional Well being

Over the past two weeks, how often have you experienced the following?

Symptom	Not at all	Several days	More than half the days	Nearly every day
Feeling anxious or on edge	☐	☐	☐	☐
Low mood or sadness	☐	☐	☐	☐
Irritability or anger	☐	☐	☐	☐
Difficulty sleeping	☐	☐	☐	☐
Feeling overwhelmed	☐	☐	☐	☐

Your Safety & Support

Have you ever had thoughts of harming yourself or others? ☐ No ☐ Yes (past) ☐ Yes (current)

If yes, please provide details (optional):

_____

Do you feel safe right now? ☐ Yes ☐ No

Medical & Health Information (to Support Coordinated Care)

Are you currently taking any medication? ☐ Yes ☐ No

If yes, please list (optional):

_____

****Any diagnosed mental health conditions?** ☐ Yes ☐ No

If yes, please specify (if comfortable):

_____

Has your GP or another health professional been involved in your care?

☐ Yes ☐ No

If yes, please provide details (optional):

_____

_____

Any relevant physical health concerns?

_____

Goals for Therapy

What would you like to achieve through therapy?

Consent, Confidentiality, Medicare & Privacy (Australian Privacy Principles)

- I understand that therapy is a collaborative process built on trust, openness, and respectful conversation.
- I understand that while therapy can be highly supportive, outcomes cannot be guaranteed and change takes time.
- I understand that information shared in sessions is confidential, except where disclosure is required by law (e.g. risk of harm).

- I consent to Open Arms Health collecting, storing, and using my personal information for therapeutic purposes in accordance with the Australian Privacy Principles (APPs) under the Privacy Act 1988 (Cth).

Privacy Statement (APP Compliance)

Open Arms Health is committed to protecting your privacy in accordance with the *Australian Privacy Principles (APPs)* under the *Privacy Act 1988 (Cth)*.

- Personal information collected in this form is used solely to provide therapeutic services and ensure your safety and well being.
- Your information is stored securely and accessed only by authorised practitioners.
- Your information will not be shared without your consent, except where required or authorised by law (including duty of care situations).
- You have the right to access, correct, or inquire about your personal information at any time.

If you have questions about privacy or wish to access your information, please contact Open Arms Health directly.

General Consent By signing below, I confirm that I have read and understood the above information and consent to therapy services with Open Arms Health.

Signature: _____

Date: ____ / ____ / _____

For Therapist Use Only

Date Received: _____

Therapist: _____

Initial Impressions / Notes:

_____
