Sydney Counselling Space

Full Name: DOB:

Address: Relationship Status:

Email: Mobile Number:

Occupation:

Emergency Contact Name: Emergency Contact Number:

- Reason for Seeking Therapy:

- Have you previously attended therapy or counseling? **Yes** **No**

- Please list any medications you are currently taking and their dosages:

Please check any conditions or diagnoses you have or have had in the past.

- ☐ Anxiety
- ☐ Depression
- ☐ Bipolar Disorder
- ☐ PTSD
- ☐ OCD
- ☐ ADHD
- ☐ Eating Disorders
- ☐ Substance Abuse
- ☐ Personality Disorders
- ☐ Chronic Pain Conditions
- ☐ Sleep Disorders
- ☐ Other: _____

Please check any symptoms you are currently experiencing.

- ☐ Mood Swings
- ☐ Sleep Problems
- ☐ Panic Attacks
- ☐ Social Isolation
- ☐ Self-Harm Urges
- ☐ Irritability or Anger
- ☐ Difficulty Concentrating
- ☐ Racing Thoughts

I understand that all information shared during therapy sessions will be kept confidential, with certain exceptions as required by law. Please read the Sydney Counselling Space confidentiality statement (attached as a PDF) before signing below.

Client's Signature: _____ **Guardian's Signature (if applicable):** _____