CLIENT INTAKE FORM

**Welcome**

Welcome to **Care TO Bloom**. In order to help your practitioner, prepare for your session, please complete the following form. If you have any questions or are unsure what to write, please let your therapist know.

**About You**

First Name: Last Name:

Date of Birth: Date of First Appointment:

Home Phone: Mobile:

Email:

Address:

Emergency Contact Name:

Emergency Contact Phone:

**Payment Information**

Payment is required on the day of the appointment unless otherwise arranged and can be made by credit card,

EFTPOS, bank transfer or BPAY.

**Referral Details**

Do you have a Mental Health Care Plan? Y N

Do you have a Referral letter for the Mental Health Care Plan, signed by your doctor? Y N

Do you have an NDIS referral? Y N

If yes, do you have a copy of your NDIS plan? Y N

If yes, who is your Support Coordinator?

Were you referred through your Employer? EAP? Y N

Who is your employer?

**Claiming Details**

Your Medicare Number:

Your NDIS Number:

Your EAP Number:

**Presenting Issues**

Please briefly describe the reason for your visit:

How long has this been a problem?

What have you already tried to fix it / reduce it / improve it?

**Cancellation Policy**

Thank you for respecting our time as we respect yours. Our cancellation policy states that your credit card will be charged **$50** of the session fee for cancellations made within **24 hours** prior to the session. If cancelled within 24 hours of the session, you will be charged **$50** of the session fee. Unless there is a medical emergency for yourself or a family member.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have read and understood this Intake Form and agree to the above conditions and terms of service.

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If client is under 18 years of age:**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, provide consent for the exchange of verbal and written correspondence

about my child’s service at **Care To Bloom** be provided to:

Parent/Guardian’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thank you for choosing **Care To Bloom** to support you in your journey. If you have any questions, please do not hesitate to **contact Care To Bloom either via telephone: 0424791888 or via email: caretobloom@gmail.com.**