Psychological

ASSESSMENTS

Psychological Assessments: Client Intake Form

Please fill out as much information as possible, simply write "Nil" if a field is not applicable.
This will help us better serve you and ensure we have accurate and complete information on file.

Client Name

Title | * First Name | Middle Name | * Last Name

Preferred Name | Pronouns | Gender

* Date of Birth DD/MM/YYYY

Age YR. AND MO.

* Preferred Method of Contact

- ☐ Client Phone
- ☐ Referrer Phone
- ☐ Emergency Contact Phone
- ☐ Client Email
- ☐ Referrer Email
- ☐ Emergency Contact Email

Client Home Phone (00) 0000-0000

Client Mobile Phone (00) 0000-0000

Client Email example@example.com

Client Address (☐ Home ☐ Work ☐ Billing ☐ Email)

Street Address Line 1 | Street Address Line 2

City | State/Province | Postal / Zip Code | Time Zone (UTC)

* Guardianship / Consent Information

- ☐ Own Decision Maker
- ☐ Child Safety
- ☐ Parent / Guardian
- ☐ Office Public Guardian
- ☐ EPOA
- ☐ Others (Specify) ________________

* Type of Referral

- ☐ Private
- ☐ NDIS
- ☐ ART
- ☐ Child Safety
- ☐ Ipswich Flexible Learning Centre
- ☐ Youth Justice
- ☐ CourtLink
- ☐ Medicolegal
- ☐ Others (Specify) ______________________________

* To whom will the assessment be billed?

- ☐ Private
- ☐ NDIS
- ☐ ART
- ☐ Child Safety
- ☐ Ipswich Flexible Learning Centre
- ☐ Youth Justice
- ☐ CourtLink
- ☐ Medicolegal
- ☐ Others (Specify) ______________________________

Referrer / Introduction Source

- [ ] Allied Health Practitioner
- [ ] Assessments and Referral Team
- [ ] Child Safety Officer
- [ ] CourtLink
- [ ] Family / Friend
- [ ] General Practitioner
- [ ] Mental Health Court
- [ ] Psychiatrist
- [ ] Social Media / Website
- [ ] Support Coordinator
- [ ] Youth Justice Case Manager
- [ ] Others

(Specify) _______________

Name of Referrer

Referrer Mobile Phone (00) 0000-0000

Referrer Email example@example.com

Emergency Contact Information

* Emergency Contact Name & Relationship

First Name

Middle Name

Last Name

Relationship

Emergency Contact Address (☐ Home ☐ Work ☐ Billing ☐ Email)

Street Address Line 1

Street Address Line 2

City

State/Province

Postal / Zip Code

Time Zone (UTC)

* Emergency Contact Phone (00) 0000-0000

* Emergency Contact Email example@example.com

Referral Information

This information will help us allocate the participant to the most suitable clinician.

1.* Please indicate the purpose of this psychological assessment:

- [ ] Application for NDIS
- [ ] NDIS Plan Review
- [ ] Brief Psychological Assessment
- [ ] Comprehensive Neuropsychological Assessment
- [ ] Standard Psychological Assessment
- [ ] Psychosocial Assessment
- [ ] ID Assessment
- [ ] ASD Assessment
- [ ] FASD Assessment
- [ ] Medicolegal Assessment
- [ ] Transition Planning

2. Are you (if self-referring) or the client seeking diagnosis or confirmation of diagnosis for the following conditions:

- [ ] Attention-Deficit/Hyperactivity Disorder (ADHD)
- [ ] Autism Spectrum Disorder (ASD)
- [ ] Intellectual Disability (ID)
- [ ] Psychosocial Disability (Specify) [Schizophrenia, Borderline Personality Disorder (BPD), Others ______________________________]
- [ ] Foetal Alcohol Spectrum Disorder (FASD)
- [ ] Global Developmental Delay
- [ ] Epilepsy
- [ ] Acquired Brain Injury
- [ ] No

3. Do you (if self-referring) or the client have a final diagnosis with any of the following conditions:

- [ ] Attention-Deficit/Hyperactivity Disorder (ADHD)
- [ ] Autism Spectrum Disorder (ASD)
- [ ] Intellectual Disability (ID)
- [ ] Psychosocial Disability (Specify) [Schizophrenia, Borderline Personality Disorder (BPD), Others ______________________________]
- [ ] Foetal Alcohol Spectrum Disorder (FASD)
- [ ] Global Developmental Delay
- [ ] Epilepsy
- [ ] Acquired Brain Injury
- [ ] No

4. * Please provide further details of the referral.

5. A. **Appointment Preferences:** Please select your preferred days so we can find the most suitable appointment.

- [ ] Monday
- [ ] Tuesday
- [ ] Wednesday
- [ ] Thursday
- [ ] Friday
- [ ] Saturday

B. * Full name of the best person to contact to book this appointment. Please provide their contact number and email if not yet stated above.

6. * **Assessment Location:** Where would you like the assessment to take place (e.g., home visit, detention centre, etc.)? We prefer to assess the client in their home environment. If this is not possible, we also have consultation rooms in the following locations: Bremer Specialist Centre (Ipswich); Holmead Road Medical Centre (Eight Mile Plains); Houston House Psychology (Toowoomba); Maple House Psychology (Toowoomba); and Medconsultants (Spring Hill).

7. * When is the report required? Please indicate when the report is required so we can prioritise our waitlist and urgent participants.

8. Are there any budget requirements? If so, kindly specify and explain further details.

9. **Reading Question:** Is the client able to read and are they capable of completing a questionnaire prior to their appointment? This is to help determine suitability for completing self-report questionnaires.

☐ Yes ☐ No ☐ Unsure ☐ Best to use informant

10. * Does the client have a trusted person or family member who can complete questionnaires or provide collateral developmental history? Please seek consent and provide their full name along with their email and contact number if not yet stated in any of the fields above.

11. Are there any current drug and alcohol concerns that we need to be aware of for the assessment? Sometimes clients are regular users and we need to be aware if they are likely to be under the influence at the time of the appointment.

12. Are there any risks or safety concerns we need to be aware of? Please explain the current living situation and any safety concerns with completing the assessment. For example, are they living in Kinship care, foster care, residential, or in remand? Is it safe to do a home visit or is a clinic/facility visit better?

National Disability Insurance Scheme (NDIS)

For NDIS Participants only, place "Nil" if not applicable.

NDIS Details: ☐ NDIA ☐ Plan Managed ☐ Self-Managed

NDIS Number & Plan Dates

000000000 START DD/MM/YYYY to END DD/MM/YYYY

Plan Management Details, Email & Contact Number

Completion

Writing your name below indicates that the information you have provided above is truthful. By completing and submitting this form, you agree for us to store this personal information on our systems according to our privacy policy (found in our website: https://www.psychologicalassessments.com.au) and for us to contact you to schedule an appointment

☐ Yes, I've checked that I've completed the form and saved my answers.

* Full Name of the client or authorised representative

Date of Completion

Note: *If, after reading this form you are at all unclear about any of the information provided, please contact the psychologist prior to your appointment.*