Psychology Services Intake Form

Participant Information

Full Name: _____

Preferred Name: _____

Date of Birth: _____

Pronouns: _____

Address: _____

Home Phone Number: _____

Mobile Number: _____

Email: _____

NDIS Number (if applicable): _____

NDIS Plan Type: ☐ Agency-managed ☐ Plan-managed ☐ Self-managed

Plan Manager (if applicable): _____

Plan Manager Email: _____

Primary Contacts

Parent/Guardian/Carer (if applicable)

Name: _____

Relationship to Participant: _____

Phone: _____

Email: _____

Emergency Contact

Name: _____

Relationship to participant: _____

Phone: _____

Referral Information

Who made the referral?

☐ Self-referral
☐ Family/Guardian
☐ Support Coordinator
☐ Behaviour Support Practitioner
☐ Case Manager / Child Safety
☐ Other: _____

Is there a current Service Agreement for Psychology?

☐ Yes ☐ No
If yes, start date: _____

Supports and Services Involved

Please list all current professionals involved in the participant's care:

Support Coordinator
Provider / Agency: _____
Contact Email/Phone: _____

Occupational Therapist
Provider / Agency: _____
Contact Email/Phone: _____

Behaviour Support Practitioner
Provider / Agency: _____
Contact Email/Phone: _____

Case Manager / Guardian
Provider / Agency: _____
Contact Email/Phone: _____

School / Education Provider
Provider / Agency: _____
Contact Email/Phone: _____

Medical / Allied Health
Provider / Agency: _____
Contact Email/Phone: _____

Other
Provider / Agency: _____
Contact Email/Phone: _____

Participant Background

Developmental / Medical History (if relevant):

_____

_____

_____

_____

_____

_____

_____

Mental Health History (diagnoses, previous therapy, assessments)

_____

_____

_____

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_____

Risk & Safety Considerations

(Information supports safe service delivery; not used for judgement or compliance.)

☐ No known risks

☐ History of self-harm or suicidal thoughts

☐ Aggression or behavioural concerns

☐ Absconding or safety concerns

☐ Medical conditions impacting participation
☐ Other: _____

Please provide details if any boxes are ticked:

_____

_____

_____

Participant Preferences

Communication Style / Sensory Preferences:

_____

_____

_____

Comfort Items (animals, sensory tools, environmental needs):

_____

_____

_____

Triggers or Situations to Avoid (if known):

_____

_____

_____

Preferred approach during dysregulation:

_____

_____

_____

Service Delivery Preferences

Where do you prefer sessions?
☐ The Stable Place (nature-based)
☐ Clinic-based (traditional in clinic sessions)

☐ Combination of both
☐ Unsure / open to recommendation

Preferred Days/Times:

_____

_____

Consent for Psychology Services

By signing below, I acknowledge that:

- Psychology services at The Stable Place may occur opportunistically, within natural environments, or through traditional clinic-based sessions depending on my preference and needs.
- Services are provided only with an active Service Agreement in place.
- Therapy is participant-led, trauma-informed, and delivered with therapeutic neutrality.
- Psychology and Community Access supports are billed separately.

Participant / Guardian Name (If applicable): _____
Participant Name: _____
Signature: _____
Date: _____

Information Sharing Consent

I consent to the psychologist communicating and collaborating with the professionals and supports listed above to assist in coordination and delivery of services.

Signature: _____
Full name: _____
Date: _____

Additional Notes (Office Use Only)

- Intake completed by: _____
- Date: _____

Initial clinical impressions: