Client Information

Strictly Confidential – please fill in and return to Melbourne Mindfulness Centre.
Do not fill in anything you are not comfortable with.
Items with * are required for bulkbilling, together with your doctor's referral.

Name* ..... Date of Birth*.....

Address*.....

Phone Numbers ....

Email .....

Medicare Number* .....exp..... (not necessary for non medicare clients)

Doctor's Name ..... (not necessary for non medicare clients)

What medication are you on, psychological medication first.

Name ..... Dose ..... Purpose .....

Name ..... Dose ..... Purpose .....

Name ..... Dose ..... Purpose .....

Have you seen a psychologist or psychiatrist before? When, for how long, and for what purpose? Did you get any diagnosis?

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What week days, 9-5 (if any) are you available to come to appointments?

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What are the first names and ages of your partner, siblings and/or children?

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What is your current living situation? Own house or flat. Renting. Living in family member's house, Living in someone else's house Homeless. Other .....

Who else lives with you? .....

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What are the main issues you would like to deal with in counselling? .....

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How much **exercise** approximately do you get each week? .....

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How would you describe your **diet**? Very healthy Healthy

Neither healthy nor unhealthy Unhealthy Very unhealthy.

How many **cigarettes** do you smoke each day on average? .....

Is this something you would like to address in sessions? .....

Describe weekly **alcohol** intake .....

..... Is this something you would like to address in sessions? .....

What other non-prescribed **drugs** do you take regularly? .....

..... Is this something you would like to address in sessions? .....

Please describe any **sleeping** difficulties .....

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