



PHOENIX

HEALTH PSYCHOTHERAPY

REBUILDING · RENEWING · MOVING FORWARD

A SAFER YOU
A BRIGHTER TOMORROW
HEALTHIER POSSIBILITIES

CLIENT REGISTRATION FORM

CONFIDENTIAL | PERSONAL | IMPORTANT

Thank you for choosing Phoenix Health Psychotherapy. This form helps us understand your needs and ensure we can provide safe, effective and personalised care.

1. PERSONAL DETAILS

Full name: _____ Date of birth: ____ / ____ / ____
Preferred name: _____ Gender (optional): _____
Address: _____
Suburb: _____ State: _____ Postcode: _____
Phone: _____
Preferred method of contact: ☐ Phone ☐ Email ☐ SMS
Occupation: _____
Emergency contact (name): _____
Emergency contact phone: _____

2. REFERRAL INFORMATION (if applicable)

How did you hear about Phoenix Health Psychotherapy?
☐ GP ☐ Specialist ☐ Previous client ☐ Online search ☐ Friend/family ☐ Other: _____
Referring doctor/health professional applicable ☐ _____
Practice name: _____
Phone: _____ Email: _____

3. PRESENTING CONCERNS

What brings you to therapy at this time?

Please select any areas that are relevant (you may select more than one):
☐ Medical/health anxiety ☐ Identity, self-esteem or confidence
☐ Diagnosis and adjustment ☐ Relationship or couple concerns
☐ Treatment and recovery ☐ Stress, anxiety or low mood
☐ Changes in physical health ☐ Life transitions
☐ Changes in sexual functioning (e.g. ED) ☐ Other: _____

4. RELEVANT MEDICAL INFORMATION

Do you have any current medical conditions or are you receiving treatment? ☐ Yes ☐ No
If yes, please provide details: _____
Are you currently taking any medication (including for mental health)? ☐ Yes ☐ No
If yes, please list: _____
Are you under the care of any health professionals (e.g. GP, specialist, physiotherapist, urologist)? ☐ Yes ☐ No
If yes, please provide details: _____

5. MENTAL HEALTH HISTORY

Have you accessed counselling or psychotherapy before? ☐ Yes ☐ No
If yes, please provide details (when, type, helpful?): _____
Have you ever been diagnosed with a mental health condition? ☐ Yes ☐ No ☐ Unsure
If yes, please provide details: _____

6. SAFETY AND WELLBEING

Have you ever experienced thoughts of harming yourself?
☐ Yes ☐ No ☐ Not currently
Have you ever attempted to harm yourself? ☐ Yes ☐ No
Are you currently at risk of harm from others? ☐ Yes ☐ No
If you answered 'yes' to any of the above, we will discuss this in more detail to ensure appropriate support and safety planning.
☐ Yes ☐ No

7. ACCESSIBILITY AND ADDITIONAL NEEDS

Do you have any accessibility, cultural, language or other needs we should be aware of? ☐ Yes ☐ No
If yes, please provide details: _____

8. ACKNOWLEDGEMENT

I confirm that the information provided is true and correct to the best of my knowledge. I understand that this information is confidential and will be used only for the purpose of providing appropriate care.

Signature: _____ Date: ____ / ____ / ____

Thank you
FOR TAKING THIS IMPORTANT STEP

Catherine Reynolds

Psychotherapist | PACFA | ACA



0400 031 114



catherinereynolds@phoenixhealthpsychotherapy.com

A SAFER YOU
A BRIGHTER TOMORROW
HEALTHIER POSSIBILITIES