

**Client Confidential Information Form**

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_\_

**Home address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Home phone: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Message may be left at this number: **Yes No**

**Mobile phone: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Message may be left at this number: **Yes No**

**Email Address: \_\_** Message may be left: **Yes No**

**Your GP’s Name and Contact details: (*Optional*)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Have you previously been seen for mental health treatment? Yes No**

If yes, please list the provider(s), treatment(s), duration(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Are you currently using any medication, prescribed or unprescribed? Yes No**

If yes, please list the medication, dosage and duration of the prescription. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**How were you referred to my practice?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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