**Thank you for completing this questionnaire, which will help provide your psychiatrist with essential clinical information to better help you. Information we collect will be treated as strictly private and confidential under the *Privacy Act 1988* and will only be used for clinical purposes.**

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| --- | --- | --- | --- |
| Name | Click or tap here to enter text. | D.O.B. | Click or tap here to enter text. |
| Gender | Click or tap here to enter text. | Occupation | Click or tap here to enter text. |
| Medicare No. | Click or tap here to enter text. | Medicare Expiry Date | Click or tap here to enter text. |
| DVA No.If applicable | Click or tap here to enter text. | DVA Expiry Date | Click or tap here to enter text. |
| Pension Card No. if applicable | Click or tap here to enter text. | Referring Dr. Name | Click or tap here to enter text. |
| Private Health Name | Click or tap here to enter text. | Private Health Member No. | Click or tap here to enter text. |
| Home Address | Click or tap here to enter text. | Email Address | Click or tap here to enter text. |
| Emergency Contact Name | Click or tap here to enter text. | Emergency Contact Ph No. | Click or tap here to enter text. |
| Emergency Contact Relationship Click or tap here to enter text. |
| Current religion if any Click or tap here to enter text. |
| Are you of Aboriginal or Torres Strait Islander origin? Yes[ ]  No[ ]   |

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| 1. **Presenting Reason**
 |
| Please briefly state symptoms or concerns:Click or tap here to enter text. |

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| 1. **Past Psychiatric Problems and Treatments**
 |
| Any past mental health diagnoses  | Yes [ ]  No[ ]  | Please Specify:Click or tap here to enter text. |
| Any past inpatient mental health admissions | Yes [ ]  No[ ]  | Please Specify:Click or tap here to enter text. |
| Previous medications used for mental health | Yes [ ]  No[ ]  | Please Specify:Click or tap here to enter text. |
| Psychologist: | Yes [ ]  No[ ]  | Name:Click or tap here to enter text. |
| Other treatment  | Yes [ ]  No[ ]  | Please Specify:Click or tap here to enter text. |

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| 1. **Other Medical Conditions**
 |
| Medical or surgical issue requiring hospital care?  | Yes [ ]  No[ ]  | Please Specify:Click or tap here to enter text. |
| Head injury  | Yes [ ]  No[ ]  | Please Specify:Click or tap here to enter text. |
| Seizure Disorder  | Yes [ ]  No[ ]  | Please Specify:Click or tap here to enter text. |
| Diabetes mellitus  | Yes [ ]  No[ ]  | Please Specify:Click or tap here to enter text. |
| Other: | Yes [ ]  No[ ]  | Please Specify:Click or tap here to enter text. |

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| 1. **Family History**
 |
| Mental health conditions?  | Yes [ ]  No[ ]  | Please specify family members and conditions:Click or tap here to enter text. |
| Substance use problem? | Yes [ ]  No[ ]  | Please specify family members and conditions:Click or tap here to enter text. |
| Any known deaths by suicide in your family?  | Yes [ ]  No[ ]  | Click or tap here to enter text. |
| General medical conditions?  | Yes [ ]  No[ ]  | Please specify family members and conditions:Click or tap here to enter text. |
| Other: | Yes [ ]  No[ ]  | Please specify family members and conditions:Click or tap here to enter text. |

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| 1. **Current Prescribed Medications**

*Please list any prescribed medications, including over the counter medications.* |
| **Medication** | **Dosage** | **Frequency of use**  |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
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| 1. **Substance Use**
 |
| **Substance** | **Used in Lifetime (Yes/No)** | **Frequency and Last Use** |
| Caffeine | Yes [ ]  No[ ]  | Click or tap here to enter text. |
| Alcohol | Yes [ ]  No[ ]  | Click or tap here to enter text. |
| Tobacco | Yes [ ]  No[ ]  | Click or tap here to enter text. |
| Benzodiazepines | Yes [ ]  No[ ]  | Click or tap here to enter text. |
| Cannabis | Yes [ ]  No[ ]  | Click or tap here to enter text. |
| Opioids | Yes [ ]  No[ ]  | Click or tap here to enter text. |
| Amphetamine-type stimulants  | Yes [ ]  No[ ]  | Click or tap here to enter text. |
| Other- please specify | Yes [ ]  No[ ]  | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
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| 1. **Education**
 |
| Highest level of school year attended? | Click or tap here to enter text. |
| Any tertiary education or training (university, TAFE, traineeship/apprenticeship)?  | Please specify:Click or tap here to enter text. |

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| 1. **Military or First Responders Questions**

*The following questions are related to any service you have completed in the Military or as first responders (Police, Firefighters, Ambulance, Lifeguards).* ***If this does not apply, please move on to question 9.*** |
| Which Service? | Click or tap here to enter text. |
| Current Rank or Rank at discharge | Click or tap here to enter text. |
| Years of Service | Click or tap here to enter text. |
| Deployments? | Click or tap here to enter text. |

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| 1. **Occupational History**
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| Current role: Click or tap here to enter text. | Full Time [ ]  Part Time[ ]  Casual [ ]  | Duration:Click or tap here to enter text. |
| Additional current role, if any:Click or tap here to enter text. | Full Time [ ]  Part Time[ ]  Casual [ ]  | Duration:Click or tap here to enter text. |
| Additional current role, if any Click or tap here to enter text. | Full Time [ ]  Part Time[ ]  Casual [ ]  | Duration:Click or tap here to enter text. |
| Please name the dates and durations of previous jobs  |
| Previous role:Click or tap here to enter text. | Full Time [ ]  Part Time[ ]  Casual [ ]  | Duration:Click or tap here to enter text. |
| Previous role:Click or tap here to enter text. | Full Time [ ]  Part Time[ ]  Casual [ ]  | Duration:Click or tap here to enter text. |
| Previous role:Click or tap here to enter text. | Full Time [ ]  Part Time[ ]  Casual [ ]  | Duration:Click or tap here to enter text. |
| Previous role:Click or tap here to enter text. | Full Time [ ]  Part Time[ ]  Casual [ ]  | Duration:Click or tap here to enter text. |
| Previous role:Click or tap here to enter text. | Full Time [ ]  Part Time[ ]  Casual [ ]  | Duration:Click or tap here to enter text. |
| Previous role:Click or tap here to enter text. | Full Time [ ]  Part Time[ ]  Casual [ ]  | Duration:Click or tap here to enter text. |
| Previous role:Click or tap here to enter text. | Full Time [ ]  Part Time[ ]  Casual [ ]  | Duration:Click or tap here to enter text. |
| 1. **Lifestyle Questions**
 |
| What do you do for leisure, hobbies and interests? | Click or tap here to enter text. |
| Do you do any activities for physical fitness? | Click or tap here to enter text. |
| Do you participate in any social, charity or recreational organisations? | Click or tap here to enter text. |

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| 1. **Privacy Consent**
 |
| In December 2000, an amendment act was passed through the Federal Parliament relating to the Privacy Act. This amendment came into effect on 21st December 2001. We require your consent to collect personal information about you. Please read this form carefully and sign where indicated below. Your psychiatrist collects information from you for the primary purpose of providing quality care. We require you to provide us with your personal details and full medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. This means we will use the information you provide in the following ways:* Administrative purposes in running our medical practice.
* Billing purposes.
* Disclosure to others in your health care, including treating doctors and specialists outside this medical practice. This may occur through referrals to other doctors or for medical tests and in the reports or results returned to us following the referrals.
* De-identified disclosure for research and quality assurance activities to improve individual and community health care and practice management.
* Emergency situations whereby medical officers/hospitals require access to patient notes for treatment purposes.

I have read the information above and understand the reasons why my information must be collected. I am also aware that my treating psychiatrist and staff treat patient information as confidential. I consent to receive text messages and/or email correspondence from staff specific for my individual needs (such as appointment confirmations) to my nominated phone and/or email address. I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of my health care and treatment given to me. I am aware of my right to access the information collected about me, except in some circumstances where access might be legitimately withheld. I understand I will be given an explanation in these circumstances. I consent to the handling of my information by this practice for the purposes set out above, subject to any limitations or access or disclosure that I notify to this practice. |
| Date: | Click or tap here to enter text. |