CRUSH therapy

Participant intake form NDIS (Adult)

This form is to be completed at the start of each new service agreement to ensure our records are up to date and any changes are on file.

If you do not feel comfortable disclosing specific information prompted in the form that is absolutely fine, please leave it blank.

Participant/Client	
Participant Full Name	
Title (e.g. Mr, Ms, Miss, Mx)	
Date of birth	
Sex (Biological)	Male / Female / Intersex
Gender	
Pronouns	
Address	
Email	
Mobile Phone	
Work Phone	
Consent to contact via email, phone, voicemail	Yes / No
Emergency Contact/Next of Kin (NOK)	
NOK Name	
NOK Number	
NOK Email	
Relationship to Client	

CRUSH
therapy

Medical Information	
Primary Diagnosis *(as stated on NDIS plan)*	
Other Diagnosis *(e.g. intellectual disability, epilepsy, ADHD, dysgraphia)*	
Allergies *(send copy of any Medication Action Plan to therapist)*	
Have you previously or are you currently received therapy service?	Yes / No **<u>If Yes</u>** please provide the following information for all other services… 1) Therapy Service Name; 2) Therapist Name; 3) Purpose of therapy/goals
Medications *(relevant)*	
Other relevant medical information…	

CRUSH therapy

NDIS Information	
Participant Name as stated on NDIS Plan	
NDIS Participant Number/ID	
Plan Dates	Start Date: End Date:
Copy of Plan Provided to CRUSH therapy	Yes / No
Funding Type	You would like to use the following plan support categories at CRUSH therapy ☐ Improved Daily Living ☐ Other ________________________
Payment Type	☐ A) NDIS Funding Self-Managed by the Participant (payments to be made before all therapy sessions) ☐ B) NDIS Funding Managed by a Plan Management Agency (Participant to provide plan-manager details. Please discuss payment options further with therapist)
A) Self-Managed	Name: Invoice Email Address: Phone: Location/Address
B) Plan Manager Details:	Name: Invoice Email Address: Phone: Location/Address:
NDIS Goal 1:	
NDIS Goal 2:	
NDIS Goal 3:	
Schedule of Support	CRUSH Therapy agrees to provide the Participant the following supports: ▪ Occupational Therapy and Sexological support

General Information	
What are your reasons for seeking CRUSH therapy services?	
Describe any goals or outcomes you hope to achieve from therapy	
Is there anything else you would like to tell us about?	
How did you hear about our service? (circle)	Referral Social Media Website Word of mouth Other: ________________________________