



CRUSH therapy

Participant intake form Private (Child)

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.

Client	
Participant Full Name	
Title (e.g. Mr, Ms, Miss, Mx)	
Date of birth	
Sex (biological)	Male / Female / Intersex
Gender	
Pronouns	
Address	

Carer 1	
Carer 1 Full Name	
Title (e.g. Mr, Ms, Miss, Mx)	
Relationship to Client	
Address	
Email	
Mobile Phone	
Work Phone	
Consent to contact via email, phone, voicemail	Yes / No
Emergency Contact	Yes / No <i>If other please Specify:</i>
Carer 2 (if applicable)	
Carer 2 Full Name	
Title (e.g. Mr, Ms, Miss, Mx)	
Relationship to Client	
Address	
Email	
Mobile Phone	
Work Phone	



Consent to contact via email, phone, voicemail	Yes / No
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Medical Information	
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Diagnosis	
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Allergies (<i>send copy of any Medication Action Plan to therapist</i>)	
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Have you previously or are you currently received therapy service?	Yes / No If Yes please provide the following information for all other services... 1) therapy Service Name; 2) therapist Name; 3) purpose of therapy/goals
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Medications (<i>relevant</i>)	
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Other relevant medical information...	
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General Information	
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What are your reasons for seeking CRUSH therapy services?	
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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: _____