THE OAK CENTRE PTY LTD

NEW CLIENT REGISTRATION FORM

(Note: All information provided is treated as confidential)

How did you hear about The Oak Centre? _____

Name _____ Age _____DOB _____

Address _____ City _____ State _____ Postcode _____

Home Phone: ( ) _____ OK to leave message? Yes / No

Mobile _____ OK to leave message? Yes / No

Email _____

Occupation _____

Marital Status (Circle): Single / Married / Separated / Divorced

Name of spouse/partner (if applicable) _____ Age _____

Have you ever been in counselling before? If so, for how long and what were the problems or issues?

_____

_____

Describe your current problem or issue that you would like to overcome or resolve:

_____

_____

Please check behaviours, feelings or symptoms that occur more than you would like:

	Anxiety		Internet games		Panic attacks
	Alcohol abuse		Loneliness		Romance novels
	Angry outbursts		Low self esteem		Self-centered behaviour
	Arguments		Mood swings		Spending money
	Avoiding people		Non-prescription drugs		Shopping
	Computer overuse		Over-eating		Sexual compulsion
	Depression		Over exercise		Sexual aversion
	Fear		Obsessive behaviour		Sexual orientation
	Gambling		Over work		Suicidal thoughts
	Internet Chat rooms		Pornography		Self-harm
	Insomnia		Prescription drug abuse		Television viewing

Briefly describe how the above checked symptoms impair your ability to function effectively: _____

_____

_____

_____

_____

_____

_____

Please check if you believe you may have suffered any of the following types of trauma in childhood or adulthood:

	Abandonment		Multiple family moves		Rejection
	Criminal charge		Natural disaster		Sexual abuse
	Emotional neglect/abuse		Over-parented		Separation or divorce
	Death of a loved one		Physical neglect		Teenage pregnancy
	Financial problems		Physical abuse		Violence in home
	Homelessness		Parental illness		Victim of crime
	Jail sentence/term		Parental addictions		Separation or divorce
	Loss of a pet		Regular criticism		Other:

Client Signature: _____ Date: _____