Child Client Details

Child's name____ Date ___________________

Age / DOB ______________________ Year level __________ School _______________________________________

Address ____

Person making referral ________________________ *NB Both parents' permission is required for children under 16 years*

Parent 1 name ____ Phone number __________________________

☐ Email ____ Signature _______________________________

☐ I agree to my child having counselling ☐ in person ☐ online (tick one or both).

☐ I have received and read the counselling information sheet. I understand the limits of confidentiality.

Parent 2 name ____ Phone number ___________________________

☐ Email ____ Signature _______________________________

☐ I agree to my child having counselling ☐ in person ☐ online (tick one or both).

☐ I have received and read the counselling information sheet. I understand the limits of confidentiality.

☐ The child has been informed of the referral and consents to come to counselling ☐ (tick to indicate yes)

Living situation / Custody arrangements ____

Names / ages of family members

Friends and other people your child is close to ____

Ethnicity ____________________________ Family cultural / spiritual aspects_______________________________________

Physical health ____

Current medication ____

Leisure activities ____

Other professionals involved ____

Previous experiences of counselling ____

Any safety concerns (including self-harm, suicidal feelings, eating disorders, aggressive or risky behaviours)

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Outline of concerns that have prompted this referral

Hoped for outcomes of counselling