Client Confidential Questionnaire

Client #		Date of Birth	/ /
Name		Initial Consult	/ /2021
Address			Postal Code:
Mobile #		Other (Home / Work)	
Email Address			
Next of Kin		Contact #	
Relationship		Confidentiality Clause Signed?	(office use only) Yes / No

✂ _ (Cut here and file separately)

Client #		**Age**	
Name		**Identify as**	M / F / L / G / B / T
Confidentiality	*"I need to inform you that everything that you say here is completely confidential unless of course I think you are going to be a danger to yourself or someone else. Is that OK with you?"* I, _____ give my consent to the terms of confidentiality outlined above.		
Client Signature		**Date: / /**	
Reason for seeking counselling			
When did you and your partner meet?	Date Met: # of Years Together:	**Marital Status** **Marriage Date** _____	☐ Single ☐ De Facto ☐ Married ☐ Divorced ☐ Separated
Country of Birth		**Years in Australia**	
Occupation			
Living situation	☐ Self ☐ Partner ☐ Children ☐ Moved out recent ☐ Parents ☐ Shared House ☐ Other ☐ Separate Living		
Do you have children of your own?	How many children (including *deceased, terminated, miscarried* etc): Names and Ages of each child:		
Family of Origin: Number of Children	**The family you were born into:**	**Position in Family:** e.g. 1 for first born	
Who is on your TREATMENT TEAM e.g. GP, psychologist, psychiatrist, acupuncturist etc			
	Name and Contact Number:	Name and Contact Number:	
Medication Yes / No	Type and dosage:	Type and dosage:	
Health Concerns	☐ Chronic Pain ☐ Digestive Issues ☐ Diagnoses e.g. Fibromyalgia; Other_____ ☐ Asthma ☐ Injuries _____		
Recreational drug intake	e.g. Drug Type and Frequency	**Recommended by:** ☐ Referral ☐ Walk-in ☐ Google Ad / Search ☐ Word of Mouth ☐ Email ☐ Website ☐ Flyer / Mail drop ☐ Other	

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Anything else I should know?	Anything that you would like me to be aware of that will affect our time together in session ☐ Addiction ☐ Legal Proceedings ☐ Betrayal ☐ Personal Injury Claim(s) ☐ Mental Health Issues ☐ Insurance Company ☐ Abuse ☐ Workers Compensation ☐ Domestic Violence – previous relationships
Sleep	Able to sleep 6-8 hours per night? Y/N Difficulty getting to sleep? Y/N Difficulty staying asleep? Y/N
Love Language	☐ Quality Time ☐ Physical Touch ☐ Acts of Service ☐ Words of Affirmation ☐ Gifts
Newsletter	Would you like to receive our infrequent newsletter – contains tips, tricks and techniques around Relationships, and Mental Health. Y/N

Please draw your family tree here:

FAMILY NAME: _____

Your Father

Age:

Alive: Y/N

Cause of Death: _____

Marital Status

☐ Together
☐ Divorced
☐ One Partner Deceased

Repartnered: Y/N
FA: Defacto/remarried?
MO: Defacto/remarried?

Your Mother

Age:

Alive: Y/N

Cause of Death: _____

Your Siblings (Brothers, Sisters, Half siblings etc) - alive or dead, terminated or miscarried etc

Please indicate using *square* for males, and *circles* for females, the names, ages and birth order of your siblings of your own biological family, in the space below. Viz:

Jack 35 Me 25 Jen 19

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Adverse Childhood Experience Questionnaire

NAME: _____

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household often … Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?	Yes / No Please circle
2. Did a parent or other adult in the household often … Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?	Yes / No Please circle
3. Did an adult or person at least 5 years older than you ever… Touch or fondle you or have you touch their body in a sexual way? or Try to or actually have oral, anal, or vaginal sex with you?	Yes / No Please circle
4. Did you often feel that … No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?	Yes / No Please circle
5. Did you often feel that … You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?	Yes / No Please circle
6. Were your parents ever separated or divorced?	Yes / No Please circle
7. Was your mother or stepmother: Often pushed, grabbed, slapped, or had something thrown at her? or Sometimes or often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?	Yes / No Please circle
8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?	Yes / No Please circle
9. Was a household member depressed or mentally ill or did a household member attempt suicide?	Yes / No Please circle
10. Did a household member go to prison?	Yes / No Please circle
Total YES/NO **ACE TOTAL:**	

Describe your relationship to your *father* in 5 words:

_____

Describe your relationship to your *mother* in 5 words:

_____

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Presenting Issues

Issues	☐ Addictions	
	☐ Abuse (Physical or Emotional or Sexual – please circle)	
	☐ Abandonment	
	☐ Affairs & Infidelity (Physical)	
	☐ Anger Management	
	☐ Alone Together	
	☐ Communication	
	☐ Domestic Duties Unfair – causing resentment	
	☐ Recreational Drug Habit – causing pain	
	☐ Finances main cause of arguments	
	☐ Fly In Fly Out Job Related Relationship Difficulties	
	☐ Jealousy & Betrayal – Real/Perceived or Virtual (please circle)	
	☐ In-laws	
	☐ Intimacy Issues	
	☐ Lack of Boundaries	
	☐ Long Distance Relationships	
	☐ Mental Illness	
	☐ Negative Communication	
	☐ Not Attracted to Partner	
	☐ Parenting Styles don't match up	
	☐ Parents suffer mental health i.e. Borderline Personality Disorder, Alcoholism etc and have to parent the parent	
	☐ Regrettable Incidents	
	☐ Staying Together for the Kids	
	☐ Space to be alone within relationship needed	
	☐ Time Management	
	☐ Trust Issues	
	☐ Trauma – Childhood or Event	
	☐ Unmet Emotional Needs	
	☐ Unsolvable Problems	
	☐ You are not on your partner's side	
	☐ Mid-life Crisis	
	☐ Virtual betrayal (online, chatrooms, social media)	

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Questionnaire

NAME: _____

Please answer the following questions for yourself within your relationship:

	Yes / No Please circle	If Yes, Rate 0-10 10=Worst
1. Are you frightened by your partner's temper?	Yes / No	
2. Are you afraid to disagree with your partner?	Yes / No	
3. Are you constantly apologising for your partner's behaviour?	Yes / No	
4. Do you have to justify every place you go or everything you do or every person you see just to avoid your partner's anger?	Yes / No	
5. Does your partner constantly put you down, then tells you they love you?	Yes / No	
6. Have you ever been hit kicked shoved or had things thrown at you?	Yes / No	
7. Do you not see family or friends or do things just because of your partners own jealousy?	Yes / No	
8. Have you been forced into having sex when you didn't want to?	Yes / No	
9. Are you afraid to break up because your partner has threatened to hurt you or themselves?	Yes / No	
10. Does your partner try to embarrass you in private or public?	Yes / No	
11. Has your partner insisted on touching you when you feel uncomfortable about it?	Yes / No	
12. Has your partner called you degrading names?	Yes / No	
13. Does your partner often yell at you?	Yes / No	
14. Does your partner make fun of you or call you names if you don't want to have sex?	Yes / No	
15. Does your partner become angry if you don't do as they say?	Yes / No	
16. Does your partner expect you to always tell them of your whereabouts?	Yes / No	
17. Does your partner tell you how to dress, how to wear your makeup, how to wear your hair?	Yes / No	
18. Does your partner follow you? Are they watching to see where you are, what you are doing, who you are talking to?	Yes / No	
19. Does your partner make all the decisions in the relationship?	Yes / No	

If any of this resonates with you, or you feel like you would like to speak to someone who is an expert in domestic violence, please call the Centre for Women and Company or DV Connect.
In a life threatening emergency, call 000.

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Newsletters, Webinars, Workshops, Retreats

Please let us know what you would like to learn more about in our communications to you. Please ensure that you "whitelist" our email address: info@nicoletteward.com.au

Tick	
	☐ **Anger** – How to better manage anger
	☐ **Betrayal** – How to recover
	☐ **Communication** – How to stop feeling like you both speak a different language
	☐ **Conflict Management** – How to ease couples conflict
	☐ **Sensitive Relationships** - How to stop walking on egg shells
	☐ **Needs and Feelings** - How to get your needs met
	☐ **Fly In Fly Out** – how to get the most from each other
	☐ **Family** – does your family confuse you?
	☐ **Repair trust relationships** - Regrettable Incidents, mishaps and breakdowns
	☐ **Stress Management** – How to better manage stress levels

Couples Classroom

Please let us know if you would like to learn more about in our online course content.

For a minimum fee of **$25** per classroom, we bring all the content to you that we discuss in the course of your sessions. Sometimes it is not always possible to take in information, and having a reference to go to is handy – especially when practicing new communication skills for example.

Which classrooms would you be interested in?

☐	**Tapping** – How to relieve anxiety, and depression
☐	**Beliefs** – How to remove limiting beliefs about you, your partner, your life.
☐	**Communication** – How to stop feeling like you both speak a different language
☐	**Conflict Management** – How to ease couples conflict
☐	**Needs and Feelings** - How to get your needs met

Payment by EFTPOS is available

Relationship Revamp Book

I am putting together a series of eBooks about how to revamp your relationship. Your feedback on these eBooks would be most welcome. Please let me know if you would like to participate as a feedback provide in this activity.

☐ Yes, I would like to participate in this activity. Please email me an eBook for review

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POLICY

Please be aware of the following when engaging in couples counselling:

Communication

Your therapist will always communicate with both of you, via email to send resources or arrange appointments. Please do not 'back channel' the therapist with information that passes between you and your partner as there is no way confidentiality can be guaranteed on the Internet.

Break up Conversations

Please note *your therapist does not facilitate break up conversations*, especially when it comes out of the blue. Please respect your partner as a human being, who deserves a comfortable, safe environment for their emotions, because when this does happen, they may experience shock and lose their social mask. This can be terribly embarrassing and shaming for your partner, in most cases, to have this done outside the home, in a public space.

Separation Transition

If both of you would like to the therapist to facilitate a break up conversation, and to manage the transition to separation, this is most certainly a possibility for us to create in session.

Domestic Violence

If there is domestic violence at play in your relationship (refer the Duluth model) please alert your therapist at the initial consult, as the therapist cannot guarantee your safety post session for what is said in session. You will need to approach **DVConnect** or **The Centre for Woman & Co**. for support, and couples counselling will only progress on the grounds of receiving support from these organisations based on their permission.

Court Letters and Correspondence

If you require these items, please advise your therapist in the first session. You will need to book a session for the letter to be generated, to ensure the prescribed requirements are met by the correspondence. Any documentation will attract a fee of ***$50 per document*** to cover therapist time, and printing costs.

Insurance

Should you wish to claim your session costs via your insurance company, please liaise directly with them. Your therapist will not engage with insurance companies in any shape or form.
Please ensure you have clearance from your insurance company prior to engaging in counselling.
As a holistic counsellor, I do not have a 'provider number' nor do I engage in the MHTP (Mental Health treatment plan). If your insurance company is prepared to engage my services, please request the *Billing Address, appropriate Item Numbers and Fee Schedule*. Your invoice will be emailed to you once you have paid it up front in session, and you can claim it from your insurer.

Mental Health Treatment Plan

Couples counselling is not covered by the MHTP. As a holistic counsellor, we do not facilitate or offer the Mental Health Treatment Plan. Our fee structure is designed to cost roughly the same as the MHTP after rebate.