Please complete this prior to attending your first appointment. If you don't know the information, or if you do not understand the question, leave the item blank. ☒ N/A = not applicable.

First Name: Surname:

Date of Birth: Today's Date:

Contact number: Medicare Card Number:

Address:

Email:

Referrer (Name, Profession, Contact Details):

☐ N/A

Emergency Contact – Name:

Emergency Contact – Contact Information:

Emergency Contact – Relationship to you:

Will contacting you using the above information impact your safety? ☐ YES ☐ NO

If YES, how would you like to be contacted:

Would you like to receive email or SMS reminders for future appointments?

☐ Email ☐ SMS ☐ None

How did you hear about PsychLab?

☐ Internet ☐ Word of mouth ☐ Doctor/specialist
☐ Advertising ☐ Another organization ☐ Other:

How would you rate your contact with PsychLab so far? *Please indicate one*

☐ Very poor ☐ Poor ☐ Average ☐ Good ☐ Excellent

Would you be interested in being contacted for feedback after you have completed services with PsychLab? ☐ YES ☐ NO

Presenting Issue: *Briefly describe your main concern or reason for making an appointment*

When did you (or others) first notice this concern? ☐ N/A

How much does the issue impact your functioning now? *Mark one number* ☐ N/A

Not much *Very Much*

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

How much does the issue distress you now? *Mark one number* ☐ N/A

Not much *Very Much*

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

How motivated are you to work on this issue? *Mark one number* ☐ N/A

Not Much *Very Much*

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Additional Concerns: ***Indicate any additional concerns and provide detail*** ☐ **N/A**

- ☐ Depression
- ☐ Alcohol/Substance Use
- ☐ Relationships
- ☐ Toileting
- ☐ Pain
- ☐ Stress
- ☐ Indecision
- ☐ Intimacy in relationships
- ☐ Jealousy
- ☐ Procrastination
- ☐ Domestic violence
- ☐ Unusual perceptual experiences
- ☐ Anxiety
- ☐ Mood swings
- ☐ Family
- ☐ Eating/Feeding
- ☐ Adjustment difficulties
- ☐ Burn out
- ☐ Stuttering
- ☐ Low self confidence
- ☐ Communication difficulties
- ☐ Self-harm
- ☐ Chronic illness
- ☐ Repetitive behaviour/rituals
- ☐ Sleeping
- ☐ Concentration difficulties
- ☐ Friendships
- ☐ Grief and loss
- ☐ Conduct (behaviour)
- ☐ Hyper-focus/obsessive
- ☐ Sexual difficulties
- ☐ Loss of direction/vigour
- ☐ Anger
- ☐ Suicidal thoughts/actions
- ☐ Near death experience
- ☐ Other:

Additional Details:

Have you sought support for these issues before? *If so, briefly list the services and approaches used to address the issues in the past.* ☐ N/A

PERSONAL HISTORY

What is your highest level of education? _____

What is your usual occupation? _____

How many hours a week do you engage in:

paid employment? _____

education/training? _____

volunteer and home activities? _____

leisure activities? _____

Who do you live with? (please list) _____

Number of dependants: _____ Number of adult children: _____

Number of children living elsewhere: _____ Number of pets: _____

What are your key strengths? _____

What are your favourite activities? _____

What gives you purpose in life? _____

What would you like to do more of? _____

Major life events: _____

Please list any of your health conditions, surgeries, or major illnesses including mental health:

☐ N/A

Issue:	Onset:	Treatment:	☐ C
Issue:	Onset:	Treatment:	☐ C
Issue:	Onset:	Treatment:	☐ C

Indicate " ☒ C " for CURRENT TREATMENT

Please list any history of prominent family illness or health concerns, including mental health issues:

☐ N/A

Family member:	Issue:
Family member:	Issue:
Family member:	Issue:

OTHER INFORMATION

What are your main goals in accessing services through the PsychLab? *(What do you want to accomplish at the end of the service?)*

Is there any other information you would like the PsychLab to know for the purpose of service provision? *If so, note them here:*

Do you have any current or imminent legal issues? *If so, please specify:*

☐ N/A

Thank you for your time in completing this form. Please bring this form and other completed paperwork with you to your first session at the PsychLab.

DASS 21

Name: *Date:*

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you *over the past week*. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0 Did not apply to me at all
1 Applied to me to some degree, or some of the time
2 Applied to me to a considerable degree, or a good part of time
3 Applied to me very much, or most of the time

1	I found it hard to wind down	0	1	2	3
2	I was aware of dryness of my mouth	0	1	2	3
3	I couldn't seem to experience any positive feeling at all	0	1	2	3
4	I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5	I found it difficult to work up the initiative to do things	0	1	2	3
6	I tended to over-react to situations	0	1	2	3
7	I experienced trembling (eg, in the hands)	0	1	2	3
8	I felt that I was using a lot of nervous energy	0	1	2	3
9	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
10	I felt that I had nothing to look forward to	0	1	2	3
11	I found myself getting agitated	0	1	2	3
12	I found it difficult to relax	0	1	2	3
13	I felt down-hearted and blue	0	1	2	3
14	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15	I felt I was close to panic	0	1	2	3
16	I was unable to become enthusiastic about anything	0	1	2	3
17	I felt I wasn't worth much as a person	0	1	2	3
18	I felt that I was rather touchy	0	1	2	3
19	I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)	0	1	2	3
20	I felt scared without any good reason	0	1	2	3
21	I felt that life was meaningless	0	1	2	3

AAQ-II

Below you will find a list of statements. Please rate how true each statement is for you by using the scale below to fill in your choice.

1	2	3	4	5	6	7
never true	**very seldom true**	**seldom true**	**sometimes true**	**frequently true**	**almost always true**	**always true**

1. My painful experiences and memories make it difficult for me to live a life that I would value.
2. I'm afraid of my feelings.
3. I worry about not being able to control my worries and feelings.
4. My painful memories prevent me from having a fulfilling life.
5. Emotions cause problems in my life.
6. It seems like most people are handling their lives better than I am.
7. Worries get in the way of my success.

TOTAL

This is a one-factor measure of psychological inflexibility, or experiential avoidance. Score the scale by summing the seven items. Higher scores equal greater levels of psychological inflexibility.

Bond, F. W., Hayes, S. C., Baer, R. A., Carpenter, K. M., Guenole, N., Orcutt, H. K., Waltz, T., & Zettle, R. D. (in press). Preliminary psychometric properties of the Acceptance and Action Questionnaire – II: A revised measure of psychological inflexibility and experiential avoidance. *Behavior Therapy.*