



"Counselling with a difference "

Address: 65 Five Mile rd Pakenham South Vic

ABN: 53 675 795 203

### Client Information

- Full Name: \_\_\_\_\_
- Preferred Name: \_\_\_\_\_
- Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_
- Age: \_\_\_\_\_
- Gender:  Male  Female  Non-binary  Other: \_\_\_\_\_
- Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ State \_\_\_\_\_ Postcode \_\_\_\_\_
- Phone Number: \_\_\_\_\_
- Email: \_\_\_\_\_
- Preferred Contact Method:  Phone  Email  Text
- Primary Language: \_\_\_\_\_
- Interpreter Required:  Yes  No

### Parent/Guardian Information (if applicable)

- Full Name: \_\_\_\_\_
- Relationship to Client: \_\_\_\_\_
- Phone Number: \_\_\_\_\_
- Email: \_\_\_\_\_
- Address (if different from client): \_\_\_\_\_
- Legal Guardian:  Yes  No

### Emergency Contact Information (Must be different from guardian)

- Full Name: \_\_\_\_\_
- Relationship to Client: \_\_\_\_\_
- Phone Number: \_\_\_\_\_
- Alternative Phone: \_\_\_\_\_

### Referral Information

- Referred By: \_\_\_\_\_

- Organisation (if applicable): \_\_\_\_\_
- Referral Contact Number: \_\_\_\_\_
- Reason for Referral: \_\_\_\_\_
- Services Required:  Counselling  Mentoring  Group Programs/Seminars

Other: \_\_\_\_\_

### Medical & Support Needs

- Does the client have any diagnosed medical conditions?  Yes  No

If yes, please specify:

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- Does the client have a disability?  Yes  No If yes, please specify: \_\_\_\_\_
- Current Medications (if applicable): \_\_\_\_\_
- Allergies (food, medication, environmental): \_\_\_\_\_
- Mental Health Concerns (if applicable): \_\_\_\_\_
- Any risk factors (self-harm, aggression, other risks)?  Yes  No If yes, please provide details:

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- Additional support needs or considerations:

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### Cultural Background & Preferences

- Cultural Identity: \_\_\_\_\_
- Religious or Cultural Considerations: \_\_\_\_\_
- Aboriginal or Torres Strait Islander:  Yes  No

### School/Education Details (if applicable)

- Current School/Institution: \_\_\_\_\_
- Year Level: \_\_\_\_\_
- Contact Person (e.g., school counsellor, teacher): \_\_\_\_\_
- Phone/Email: \_\_\_\_\_

### Legal & Safety Considerations

- Is there a current Child Protection involvement?  Yes  No

If yes, Caseworker Name & Contact:

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- Are there any court orders in place?  Yes  No If yes, please attach relevant documentation.

### Invoicing Details

- Who is responsible for payment?  NDIS  Parent/Guardian  Third-Party (Specify below)
- Invoicing Name: \_\_\_\_\_
- Organisation (if applicable): \_\_\_\_\_
- Billing Address: \_\_\_\_\_
- Phone Number: \_\_\_\_\_
- Email for Invoicing: \_\_\_\_\_
- NDIS Participant Number (if applicable): \_\_\_\_\_
- Plan Managed by:  Self  Plan Manager  NDIA
  - If Plan Manager, Company Name: \_\_\_\_\_
  - Contact Person: \_\_\_\_\_
  - Email: \_\_\_\_\_

**Consent & Acknowledgment**  I give consent for NextGen Youth Services to provide support services and collect necessary information to assist in service delivery.  I acknowledge that I have read and understood the privacy policy of NextGen Youth Services.  I understand that if payment is required, invoices will be issued to the party listed above and must be paid within the agreed timeframe.  I confirm that all information provided in this form is accurate to the best of my knowledge.

Client/Guardian Name:

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Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

### Office Use Only

- Intake Completed By: \_\_\_\_\_
- Date Received: //\_\_\_\_
- Assigned Caseworker: \_\_\_\_\_
- Initial Assessment Notes: \_\_\_\_\_

**Office Use Only**

- Intake Completed By:

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- Date Received: \_\_\_/\_\_\_/\_\_\_

- Assigned Caseworker:

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- Initial Assessment Notes:

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"Every step forward, no matter how small, is a step towards growth."



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