

# CLIENT INTAKE FORM

Adult Name: .....

DOB: .....

OR  
ATTACH PATIENT LABEL

PLEASE COMPLETE THIS FORM AND RETURN TO O'CONNELL FAMILY CENTRE AFTER SIGNING BY FAX OR POST.

If you are unable to complete this form please contact us on 8416 7600.

*Circle or indicate response with 'X' where appropriate*

Parent Surname: .....	First Name: .....	DOB: .....
Address: .....	Phone Number: .....	
	Mobile Number: .....	
Next of Kin .....	E-mail Address: .....	

Primary Child - Surname: .....	First Name: .....	DOB: .....
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Second Child - Surname: .....	First Name: .....	DOB: .....
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Have you and / or your child ever attended Mercy Hospital for Women, Mercy Werribee Hospital or Mercy Health - O'Connell Family Centre?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
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Are you currently on the Waiting List or booked with another Early Parenting Centre?	<input type="checkbox"/>	<input type="checkbox"/>
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MCH Nurse: .....	Centre/Suburb: .....	Phone No: .....
Family Doctor: .....	Phone No: .....	
Permission to contact MCHN		<input type="checkbox"/>
Permission to contact doctor		<input type="checkbox"/>
First language: .....	Do you need an interpreter?	<input type="checkbox"/>
	If yes, state language	<input type="checkbox"/>

PLEASE INDICATE YOUR CONCERNS ABOUT YOUR CHILD:

	YES	NO		YES	NO
Was your baby born more than 5 weeks prematurely?	<input type="checkbox"/>	<input type="checkbox"/>	Feeding Concerns: Breast feeding	<input type="checkbox"/>	<input type="checkbox"/>
Did your baby weigh less than 2500 gms at birth?	<input type="checkbox"/>	<input type="checkbox"/>	Formula feeding	<input type="checkbox"/>	<input type="checkbox"/>
Does your child have a disability?	<input type="checkbox"/>	<input type="checkbox"/>	Poor weight gains	<input type="checkbox"/>	<input type="checkbox"/>
Does your child have a chronic illness?	<input type="checkbox"/>	<input type="checkbox"/>	Not taking solids	<input type="checkbox"/>	<input type="checkbox"/>
Do you have concerns about your child development?	<input type="checkbox"/>	<input type="checkbox"/>	Fussy with food	<input type="checkbox"/>	<input type="checkbox"/>
Do you have concerns about your child behaviour?	<input type="checkbox"/>	<input type="checkbox"/>	Is your child prescribed regular medication?	<input type="checkbox"/>	<input type="checkbox"/>
Specify other concerns			State medication :		

INFORMATION ABOUT YOURSELF:

	YES	NO		YES	NO
Are you parenting this child alone?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have a chronic illness or health issue?	<input type="checkbox"/>	<input type="checkbox"/>
Do you mostly enjoy parenting	<input type="checkbox"/>	<input type="checkbox"/>	Current medication: (please state):		
Who do you have to support you? Partner / family / friends			Do you have a disability	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a past mental health issue?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have a learning difficulty	<input type="checkbox"/>	<input type="checkbox"/>
Current mental health issue - anxiety / depression?	<input type="checkbox"/>	<input type="checkbox"/>	Do you feel alone or lonely	<input type="checkbox"/>	<input type="checkbox"/>
Who supports you with your mental health? GP/ Psychiatrist / Psychologist / Counsellor / Support Group / MCHN			Are you linked with a regular mothers or play group or community group	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a current or past drug history	<input type="checkbox"/>	<input type="checkbox"/>	Does your partner have a disability?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a current or past alcohol history	<input type="checkbox"/>	<input type="checkbox"/>	Does your partner have a chronic illness or significant health issue?	<input type="checkbox"/>	<input type="checkbox"/>

CLIENT'S SIGNATURE:

<b>OFFICE ONLY</b>	Date received form: / / HR HP MR LR	Date Phone Call: / / Staff Initial
	Final : HR HP MR LR	Date Phone Call: / / Staff Initial
	Outcome: R D/S N/R	Date Returned Call: / / Staff Initial

\*M0220909\*



CLIENT INTAKE FORM MR 022-A