

Intake Registration Form



OFFICE ONLY

Date of Referral: (if applicable) _____ Date of Intake: _____ Completed by: _____
Service ID: _____ Program referred to: _____ By: _____

ALL CLIENT DETAILS AND INFORMATION ARE ONLY STORED FOR 12 MONTHS AFTER NO CONTACT.

1. Details of Applicant

*First name:

Middle name:

*Last name:

Preferred name:

*Gender: (Please select one only)

Male

Female

Intersex

Transgender

Non-binary

Other

*Date of Birth:

*Address Line 1:

Address Line 2:

*Suburb:

Postcode:

Contact and Communication:

*Mobile phone number:

Home phone number:

Personal email address:

Do you have any issues with literacy/reading?

No

Yes

How can we best contact you?

Text

Phone call

Email

2. *Indigenous status: (Please select one only)

Aboriginal

Torres Strait Islander

Both Aboriginal and Torres Strait
Islander

Neither Aboriginal nor Torres Strait
Islander

Undisclosed

3. *Culturally and Linguistically Diverse (CaLD) status: Please Tick if Yes

4. Country of birth:

Language at home

5. *Do you require an interpreter?

Yes Language:

No

6. Do you have any cultural needs/practices that we need to take into account?

No

Yes

(If yes please provide detail):

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7. Do you have a disability? (Select any that apply)

No disability	Intellectual/ Learning	Psychiatric	Sensory / Speech
Physical/ Diverse	Multiple Disabilities	Not stated	

8. Household composition:

Couple	Couple with dependent(s)	Sole parent with dependent(s)
Single person (living alone)	Group (related adults)	Group (unrelated adults)
Widow / Widower	Divorced / Separated	Other

If other, please provide details:

9. What is your current household tenure?

Owner	Purchaser	Renter - Private	Renter - Public
Renter - Transitional Housing	Renter – Community Housing	Rent free	Homeless
Refuge	Caravan	Boarding/Lodging House	

10. What is your current employment status?

Employed – Full Time / Casual / Part Time (please circle)	Unemployed for less than 1 year
Unemployed for more than 1 year	Not in the labour force
Never been employed	Currently caring for children

11. What is your source of income? (Please select one only)

Age pension	Business income	Carer payment	Disability pension
Family and friends	Jobseeker payment	No income	Other
Paid employment	Parenting payment	Private Savings/superannuation	

Income per fortnight before Tax: \$

12. Who are you seeking assistance for? (Please add children's full details below if you are engaging in family dispute resolution in relation to parenting or grandparenting matters)

yourself	yourself and a partner	yourself and family grouping
yourself and another person	a dependent child / children	

If you are seeking assistance for someone other than yourself, please provide details

Name	Gender M/F	Date of Birth	Ethnicity	Relationship (i.e. Partner/child)	Disability
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13. *What is the main reason you are accessing our service? (Please select one only)

- | | | | |
|----------------------------------|------------------|--|------------------------|
| Children/youth | Children in Care | Relationships | Grief and Loss |
| Gambling Harm | Physical health | Financial Hardship | Financial Counselling |
| Family relationships | Reunification | Parenting | Adult Justice support |
| At risk behaviour | Mental health | Youth Justice support | Housing / Homelessness |
| Family and Domestic Violence | | AOD Alcohol and other Drugs | |
| Age-appropriate development | | Family Dispute Resolution Parenting/Property | |
| Trauma and Attachment | | Men's Behaviour Change Program | |
| Family Separation – Family Court | | Group (Name) | |

14. Other reasons you are accessing our service? (Please identify)

15. Emergency Contacts: (include Carer details where applicable)

Surname	Given name	Relationship	Contact number	Address
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(To be entered on Penelope Database as "Collateral Contacts")

16. How did you hear of our service?

- Another agency or Organisation
- Non-agency - Family / Friend / GP / Other Website /
- Word of Mouth / previous client
- Government Department Referral

Thank you for completing this form.

1. Save the completed form.
2. Return this form by email to the office of your choice if you are initiating the service, or as indicated in your invitation letter.
3. Once we receive your form, you will be contacted by the administrative team of that office for the next steps.

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OFFICE ONLY:

Explain to the client the circumstances (e.g. COVID) which would prevent a face-to-face appointment from going ahead.

Date and Time of Appointment offered:

Video

Phone

Face-to-Face

No appointment offered – client has been advised a follow-up call will be made

Timeframe provided

Notes: