Thank you for choosing to work with the Made It Clinic. There are a few things you should know before we begin.

### 1. Confidentiality and Access to Your Information

As part of providing services to you, we (the staff at the Made It Clinic) need to collect and record personal information from you that is relevant to your situation such as your name, contact information, medical history, and other relevant information for administration and service provision. This information will be handled and stored securely in accordance with our Privacy Policy, which is available from the clinic upon request. ***The information collected will remain confidential, which means that is not released without your permission.*** A psychologist may refuse access to client records under specific circumstances, usually to protect the client from harm. The Made It Clinic staff will have access to your information in order to complete administrative tasks. If you have been referred by a GP or specialist, we will provide your information to the referrer. ***There are limits to confidentiality pertaining to risk management, mandatory reporting, and legal matters.***

### 2. Fees, Payment, and Cancellation

We will usually tell you what the fees are when you book the appointment. The complete fee schedule is available on request from the clinic or can be located at *www.madeitclinic.com/services.html*. If you need to cancel an appointment, please give the clinic at least 24 hours of prior notice. If two appointments are missed without prior notice, we will cancel further appointments.

### 3. Your Rights

Psychologists practice under a strict code of ethics that serves to uphold our conduct in regard to Respect, Propriety, and Integrity. Essentially, this means that you will be treated with respect regardless of your background or beliefs. You will receive clear communication regarding the services, including the framework of practice and estimated time frames of intervention. You can ask your psychologist any questions about the service at any time. The APS Charter will be provided to you upon request.

If you are unhappy with the services provided, please let us know in the first instance. If you are unable to let us know, or the issue is not resolved, you have the right to notify the Office of the Health Ombudsman (www.oho.qld.gov.au).

### 4. Research and Training

We are often involved in training and research. This helps to continue our professional development and grow the profession. If we would like to use your information for research or training, we will ask you. Sometimes you will have to fill out additional consent forms.

Please ask staff any questions you have before you sign the consent form. Further information about the clinic, our values, and frequently asked questions can be found at our website, *www.madeitclinic.com*

***I have read and understood the information provided to me including the fees. I agree to service provision under these terms and conditions.***

NAME _____ SIGNATURE _____

DATE _____

**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:

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 the Made it Clinic?

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

How would you rate your contact with the Made it Clinic 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 the Made it Clinic? ☐ 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 <u>hours a week</u> 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 Made it Clinic? *(What do you want to accomplish at the end of the service?)*

Is there any other information you would like the Made it Clinic 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 Made it Clinic.**

# DASS21

*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 |

*Lovibond, S.H. & Lovibond, P.F. (1995). Manual for the Depression Anxiety Stress Scales. (2nd. Ed.) Sydney: Psychology Foundation.*

# 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.*