GPS² Patient Intake Form
Psychological Health

Welcome to GPS². We ask that you please take some time to complete this form to the best of your knowledge. If it would help, please feel free to complete this Form with your General Practitioner. The Form will allow the GPS² Specialist to get to know more about you and your medical condition(s), in order to provide medical advice and prepare a report for your General Practitioner.

We ask that you please complete this form prior to your appointment and bring it with you on the date of the appointment, so there will be no delay when you arrive. If you forget to bring it with you, we will ask you to complete the Form on arrival.

The contents of this Form are confidential and will be kept as part of your medical records. If you have any questions about confidentially or completing any aspects of the form, please contact us for clarification on 1800 477 246.

Date of Appointment:	Date Form Completed:	Date of Birth:
Name:		
Address:		
Phone:	Height:	Weight:
Marital Status:	Dependent Children:	
Highest Level of Education:		
General Practitioner's Name:		
General Practitioner's Address:		
Smoker? ☐ Yes	☐ No (tick one)	Amount per week:
Drink Alcohol? ☐ Yes	☐ No (tick one)	Amount per week:
Take Recreational Drugs? ☐ Yes	☐ No (tick one)	Amount per week:
Current Medications (please also list dosage/frequency if possible)		

WORK HISTORY	
Are you presently working? □ Yes □ No (please tick)	If no, when did you cease work?
Whom do you work for (company name)?	
Are you currently working: Full time:.....(hours) or Part time:.....(hours and days)	
Are you working normal duties? □ Yes □ No	Are you working modified or alternative duties? □ Yes □ No
Work Restrictions (please specify):	

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PAST MEDICAL HISTORY
My general state of health is:
Please address the following: Have you had a prior psychological illnesses? If so, when and what was the diagnosis and treatment you had.
Have you had a prior work-related psychological illnesses? If so, when and what was the diagnosis and treatment you had.
Have you had any prior psychological treatments (including therapies, medications or hospitalisations)? Please describe when, by whom and nature of treatment):
Do you have any other health problems or allergies? (please specify):
Have you experienced any past traumatic events? If yes, please detail what and when:

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History of Current Illness: Occupation at the time of illness:	
Emplpoyer at time of illness:	
How long employed by that company?	Date of Illness (onset of symptoms):
Date you first stopped work:	
What happened?	
Describe all your intial symptoms:	
When did you first seek medical attention?	
From whom?	
What other medical practitioners have you consulted?	
Describe your current symptoms:	
Aggravating factors (please describe any current stressful issues/events):	

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Relieving Factors (please describe what helps you or would help you alleviate your symptoms):
Describe all your intial symptoms:
When did you first seek medical attention?
From whom?
What other medical practitioners have you consulted?
Describe your symptoms:
Aggravating factors (please desbribe any current stressful issues/events):
Have you been hospitalised because of your illness: □ Yes □ No If yes, please provide circumstances and dates:

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What treatments have you had so far as a result of this illness. Please also provide frequency of treatment and name of the treatment provider(s):
Please describe your current activities of daily living (what do you do to cope with your illness):
What are your treatment goals:
What are your return to work goals:

Family History: Has anyone in your family been diagnosed with or treated for a psychological illness. If yes, please specify whom, their diagnosis (if known) and when (if known):
Patient Signature:
Date:

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