

Azelene Williams

FROM FEAR TO FREEDOM

Bachelor of Social Work, DipHCounselling, DipCommServices, CertDomFamViolence, CertSexIntelligence
Author | Domestic Violence Advocate | Program Facilitator | Community Leader | Holistic Counsellor | Social Worker

ABN: 60 363 880 682

VIOLENCE AGAINST WOMEN
LET'S STOP IT
AT THE START

RESPECT.GOV.AU/COMMUNITY

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CLIENT INTAKE FORM

Client Information

First Name: _____ Surname: _____

Birth Date: ___/___/___ Age: _____ Gender: _____

E-mail: _____ Cell Phone: _____

Home Address: _____

Suburb: _____ Code: _____

I am under 18 please mail my parents at: _____

School: _____ Year: _____

Relationship Status: (For Teens in Relationships)

- I am not in a relationship
- I am in my first relationship
- I am in my second relationship
- My relationship is healthy
- My relationship is un-healthy

Parent / Guardian:

Name: _____ Surname: _____

Relationship: _____ Cell Phone: _____

Home Address: _____

Parent / Guardian:

Name: _____ Surname: _____

Relationship: _____ Cell Phone: _____

Home Address: _____

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In case of Emergency:

Name: _____ Surname: _____

Relationship: _____ Cell Phone: _____

Home Address: _____

General Health and Mental Health Information:

Who referred you: _____

Other: Facebook, Website, Word of Mouth, Event Contact

Are you currently seeing a Psychologist or Counsellor? Yes No

Have you previously received any type of mental health services: Yes No
(Psychiatric Services, Psychotherapy? Counselling)

Name of therapist: _____ Date Visited: _____

Reason for previously receiving support: _____

What is the main reason for seeking support from Azelene Williams at From Fear to Freedom and any other information you think we need to know:

How long have you experienced this situation / issue? _____

Severity of this situation / issue: Not Bad 1 2 3 4 5 6 7 8 9 10 Very Bad

How are you currently managing your problem: _____

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Have you ever been on medication for your situation / issue: Yes No

Please list and explain what the medication was for: _____

Have you had any side effects on this medication: Yes No N/A

Have you spoken to your GP about these side effects: Yes No N/A

Family Mental Health History:

In this section below identify if you a family member identify with any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, mother, grandmother, uncle, brother, sister, etc.).

Alcohol/substance Abuse	Yes	No	Who: _____
Anxiety Disorder	Yes	No	Who: _____
Clinical Depression	Yes	No	Who: _____
Domestic Violence	Yes	No	Who: _____
Eating Disorders	Yes	No	Who: _____
Obesity	Yes	No	Who: _____
OCD	Yes	No	Who: _____
Schizophrenia	Yes	No	Who: _____
Suicide Attempts	Yes	No	Who: _____
Bipolar Disorder	Yes	No	Who: _____
Dementia	Yes	No	Who: _____
ADHD	Yes	No	Who: _____
Autism	Yes	No	Who: _____
PTSD	Yes	No	Who: _____
Self-harm	Yes	No	Who: _____
Narcissistic Personality Disorder	Yes	No	Who: _____

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General Health and Mental Health Information:

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific health problems you currently experience:

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific sleep problems you are currently experiencing:

Do you get nightmares or dream a lot? Yes No _____

Can you remember your dreams? Yes No _____

3. How many times per week do you generally exercise? _____

What types of exercise do you participate in? _____

Would you benefit from Walk and Talk Counselling Sessions? Yes No

4. Please list any difficulties you experience with your appetite or eating patterns:

5. Are you currently experiencing overwhelming sadness, grief or depression?

Yes No If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks or have any phobias?

Yes No If yes, when did you begin experiencing this? _____

7. Do you currently have any suicidal thoughts? Yes No

8. Have you ever experienced suicidal thoughts? Yes No

9. Are you currently experiencing any chronic pain? Yes No If yes, please

describe: _____

10. Do you drink alcohol? Yes No N/A

11. Do you drink alcohol more than once a week? Yes No N/A

12. Has alcohol ever had a negative impact on your life? N/A Yes No (If yes explain)

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13. Would you like to drink less or quit alcohol use? Yes No N/A
14. Have you ever used recreational drugs? Yes No N/A
15. How often do you engage recreational drug use? Daily Weekly Monthly N/A
16. What drugs do you use / or have you used in the past? Please list: _____

Additional Information:

1. Do you consider yourself to be spiritual or religious? Yes No
- If yes describe your faith or belief: _____

2. What do you consider to be some of your strengths? _____
- _____
- _____
- _____

3. What do you consider to be some of your weakness? _____
- _____
- _____
- _____

4. What would you like to accomplish out of your time in therapy? _____
- _____
- _____
- _____

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5. Tick the Therapies or Techniques that might be of interest to you:

- Talk Counselling Therapy
- Holistic Counselling
- Art Therapy
- Sand Tray Therapy
- Clay Therapy
- Goal Setting
- Mind Mapping
- Walk and Talk Counselling
- Journaling
- Vision boards

Herewith I declare that I have answered all these questions truthfully. If there is any change in the questions, I have answered I will inform Azelene Williams to make the necessary changes to my client intake form.

Parent Name

Date

Signature



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Consultation Booking

(You do not have to bring the next two pages to your next consultation)

Your first consultation will be a complementary 30-minute session. These consultation sessions are normally online. However, you can book a face-to-face consultation if that suits you best.

In our first consultation, I will take the time to learn more about you and your reason for seeking counselling and what goals you might have for our time together. I will use this opportunity to collaborate with you regarding what type of therapy might best suit your individual needs, based on your personal history and intent. I will also talk to you about the fees structures I have available. After the first consultation you will receive a client intake form to complete.

Our following counselling consultations might involve therapeutic conversations, art therapy, walk and talk therapy, or other types of experiential activities to help you discover more about your psyche, problematic relationships, past trauma, and personal dilemmas. These sessions generally last 45 minutes and will be most helpful to you if they are scheduled regularly (usually once per week). My approaches in each session will likely change over time, as your needs change.

Fees Structure and Payment

- **Online Complementary 30-min Consultation** **Free**
- **Face-to-Face / Online / Walk and Talk Sessions 45-min** **\$120**
- **Face-to-Face / Online / Walk and Talk Sessions 60-min** **\$130**
-

Session Bundles

- **Two Consultations 90 min in total** **\$220** *(Saving of \$20)*
- **Three Consultations 135 min in total** **\$300** *(Saving of \$60)*
- **Four Consultations 180 min in total** **\$360** *(Saving of \$120)*
- **Five Consultations 225 min in total** **\$400** *(Saving of \$200)*
- **Six Consultations 270 min in total** **\$420** *(Saving of \$300)*



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Payments are due prior to your next appointment in cash or EFT. We have found it is best to take payments before the next consultation. Session Bundles are also paid in full before the first session. Please ask for pensioners discount.

Account Name:	Azelene Williams	Reference:	Client Name & Surname
Account Number:	349 280	BSB:	036 237

Counselling Services:

When life's difficulties become overwhelming, counselling is a therapeutic process that can offer support and a pathway toward reaching one's goals in mental health. I offer both short-term and long-term counselling, based on a client's need. Counselling options are a collaborative decision, and I work with my clients to help them find the inner strength they need to change their lives for the better. The counselling sessions is about you and what you want to discuss or want to disclose. My consultation space is a non-judgemental space where I offer proven, holistic ways to support you:

Services include but is not limited to the following:

- Marriage, Separation, Divorce
- Intimate Partner Violence
- Family Relationships
- Teen Relationships
- Grief and Loss
- Historical Trauma
- Managing Anxiety and Depression
- Anger Management
- Parenting Skills
- LGBTQI relationships
- Goal setting
- Counselling for young people
- Helping Young People Become More Resilient, Capable and Connected.
- Online support

Therapy or Techniques I might suggest:

- Talk Counselling Therapy
- Holistic Counselling
- Art Therapy
- Sand Tray Therapy
- Clay Therapy
- Goal Setting
- Mind Mapping
- Walk and Talk Counselling
- Group Therapy

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From Fear to Freedom offers confidentiality under the Family Law Act. All personal information is securely stored, and, under the Privacy Act, requests can be made to access your personal information and ensure correction of any inaccuracies. For any further information regarding your consultation with me, feel free to send me an email at azelenewilliams@gmail.com or contact me directly on my cell phone **0405 246 176**.

Consent and Agreement for Child under 18 years of age.

I _____ (Parent Name) give consent that _____ (Child Name) undergo Psychotherapeutic Holistic Counselling with Azelene Williams at From Fear to Freedom.

I fully understand the process of counselling and art therapy and the outcome I can expect. I fully understand that counselling is a process and not an immediate cure and does not in any way replace any medical treatment my child might need now or in the future.

I fully understand that should my child's life be in danger in any way I need to inform the Police and Azelene immediately.

I do understand that the Azelene has the right to report any emotional, physical or sexual abuse to authorities if needed.

If Azelene feels at any point that she is not able to meet the outcomes, she will discuss it with you, and then either end the services, or refer your child to the appropriate professional.

I do understand that Azelene has a current, working with children check, and police clearance, and is qualified to work with children.

Are you the parent: Yes No Legal Guardian: Yes No

Full Name of Child: _____ Age: _____

Age: _____

Name Parent / Guardian: _____ Date: _____

Signature Parent / Guardian: _____

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