Self-Referral Registration

headspace Alice Springs

Date	

General Information			
First Name		Last Name	
Alias / Skin Name / Preferred Name (i.e. Kuminljai)			
DOB		Gender	☐Female ☐Male ☐ Gender Diverse ☐Indeterminate ☐Other
Sexuality	☐Heterosexual (Straight) ☐Lesbian ☐Gay ☐Bisexual ☐Other Sexuality (i.e. Queer, Pansexual, etc.) ☐Questioning ☐Choose not to answer		
Please specify if 'Other':			
Relationship Status	☐Single/Never Married ☐In a relationship/Married/De Facto ☐Divorced ☐Separated ☐Widowed ☐Choose not to answer		
Indigenous?	☐No ☐Aboriginal ☐Torres Strait Islander ☐Aboriginal and Torres Strait Islander ☐Choose not to answer		
Ethnicity (other than Aboriginal and/or Torres Strait Islander)			
Country of Birth		Town of Birth	
If not Australian, year of arrival?			
Main Language Spoken at Home		Other Languages	

Contact Details					
Address					
Town		State		Postcode	
Mobile Number					
Email					

Emergency Contact Details			
Name		**Relationship**	
Mobile Number			

Next of Kin Details (If not the same as Emergency Contact Details)			
Name		**Relationship**	
Mobile Number			

Health Care Card Information					
Medicare Number		**Reference Number**		**Expiry**	
(If applicable) Centrelink Health Care Card Number				**Expiry**	

Service Information		
What support would you like to access? (Tick more than one if applicable)	☐Doctor ☐Psychologist/Mental Health Counselling ☐Work/Vocational Support ☐AOD	
Please tick which boxes below apply to you for relevant information relating to why you are accessing our youth service:		
☐Feeling Sad or Depressed	☐Sexual Health	☐Doctor Check Up
☐Feeling Anxious	☐Sexuality Confusion/Questioning	☐Anger and Aggression
☐Concerned Sleeping	☐Gender Confusion/Questioning	☐Bullying
☐Concerned Eating	☐Living Situation	☐Stress
☐Self Esteem/Body Image	☐Work and Study	☐Loneliness
☐Relationship Issues	☐Disruptive Thoughts	☐Nightmares
☐Substance Abuse (Alcohol/Drugs) ☐Financial Situation	**Other:**	
How long has/have this/these been an issue for you?	☐Days (1-6) ☐Weeks (1-3) ☐Months (1-11) ☐Years (1+) ☐Unsure	

Please return this completed form to our headspace Reception in person or by fax or email.