

Momentum Mental Health Application

Momentum Mental Health is a community mental health service focussed on helping you improve your wellbeing. By filling in this form you are expressing an interest in gaining access to a mental health service that is responsive to your needs.

Is Momentum suitable?	Yes	No
Are you 16 – 17 Years old?		
Are you 18 years old or above?		
Would you like to improve your mental wellbeing?		
Are you willing and able to engage in Momentum programs the way they are intended?		
Are you willing to identify and work toward a goal with a Wellbeing Coach?		

Please circle the ways in which you would like to engage with Momentum initially:

- 1:1 Coaching (Not available to those accessing the NDIS)
- Group Coaching
- I'm not sure yet.

How did you hear about Momentum Mental Health?

- Your GP
- Friends or Family
- An Organisation: _____
- Other: _____

Why are you looking to engage in Momentum Mental Health? How is your mental health impacting on your social, personal and/or work life?

We acknowledge that forms can feel daunting, however, so that we can respond in the best way possible, please complete the form to the best of your ability. Completed forms can be emailed to admin@momentummentalhealth.com.au or delivered in person.

You will be contacted within 2 Business Days regarding your eligibility.

Personal information	
Full Name: Any previous names? Phone: Mobile: Date of Birth: (Our age criteria is 16+)	Address: Postcode: Email:
Gender	
<input type="checkbox"/> Male	<input type="checkbox"/> Female
<input type="checkbox"/> Other	<input type="checkbox"/> Prefer not to say
Indigenous Status / Cultural background	
<input type="checkbox"/> Aboriginal	<input type="checkbox"/> Torres Strait Islander
<input type="checkbox"/> Both Aboriginal & Torres Strait Islander	<input type="checkbox"/> CALD/Other: _____
<input type="checkbox"/> Neither Aboriginal or Torres Strait Islander	<input type="checkbox"/> Country of Birth: _____
Preferred Contact Method	
<input type="checkbox"/> Phone	<input type="checkbox"/> Email
<input type="checkbox"/> Letter	<input type="checkbox"/> SMS (text message)
<input type="checkbox"/> Other: _____	
Are you accessing any other Community Services, or are you connected with any other Organisations that assist with your Mental Health (e.g. RFQ, Lives Lived Well etc.)? <input type="checkbox"/> YES <input type="checkbox"/> NO Please provide details:	
Do you have a current NDIS plan that is <u>PLAN</u> or <u>SELF</u> Managed? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, what is your NDIS number and when does your plan expire? Number: Expires:	Who is your NDIS Support Coordinator/Plan Manager? Name: Organisation: Phone Number: Email:

REQUIRED QUESTION:

Have you accessed Mental Health services through the Darling Downs Health in the last 3 months?

YES NO (e.g. ACT Team, AMHU, CCU, Baillie)

Your Support Team

Health professionals supporting you with your mental wellbeing:

General Practitioner

Name:

Clinic:

Telephone Number:

Psychologist / Psychiatrist

Name:

Clinic:

Telephone Number:

Other contacts supporting your mental health and wellbeing:

Organisation name:

Name:

Telephone:

Email:

Organisation name:

Name:

Telephone:

Email:

Emergency Contact – Who would you like us to contact in an emergency?

Name:

Telephone:

Email:

Relationship to you:

Do you require assistance in any of the following areas?			
<input type="checkbox"/>	Mobility	<input type="checkbox"/>	Language barrier / Interpreter Service
<input type="checkbox"/>	Visual impairment	<input type="checkbox"/>	Learning disability / difficulty
<input type="checkbox"/>	Hearing impairment	<input type="checkbox"/>	Physical / Sensory Impairment
<input type="checkbox"/>	Chronic illness	<input type="checkbox"/>	Other (please provide details)
Do you have any Medical conditions (including allergies) which could require urgent medical attention and/or affect their ability to engage with this service?			<input type="checkbox"/> YES <input type="checkbox"/> NO
If YES, please provide details 			
Behaviour Have you ever been accused or convicted of violent / aggressive behaviour or sexually inappropriate behaviour? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES how long ago (please circle)? <i>Within the last 12 months Within the last 5 years Over 5 years ago</i> Is there a risk of continuing aggressive or sexually inappropriate behaviour? <input type="checkbox"/> YES <input type="checkbox"/> NO Are there known scenarios or potential triggers where risk behaviours are likely to arise? <input type="checkbox"/> YES <input type="checkbox"/> NO Are you known to the police or on probation? <input type="checkbox"/> YES <input type="checkbox"/> NO			
If you answered YES to any of the questions above, please give details including relevant dates. PLEASE NOTE this information is used to assess suitability for membership and any possible risks to the safety of the potential member, staff, and other members of Momentum.			