**Confidential Client Intake for Counselling or Hypnosis Treatments**

**BASIC INFORMATION**

|  |  |
| --- | --- |
| Name |       |
| Address |            |
| Town |       |
| Email |       | Phone |       |
| Occupation |       |
| Education |       |
| Other training |       |
| Things you’re good at or enjoy |       |
| Date of Birth *(D-M-Y)* |       |
| Relationship status |   | How many years? |       |
| Next of Kin or emergency contact |       | Number of children |       |
| Medicare number |       |
| Healthcare provider |       | Healthcare number |       |
| How did you hear about this service? |       |

**HEALTH INFORMATION**

|  |  |  |  |
| --- | --- | --- | --- |
| General health status |       | How long since last physical? |       |
| Doctors name |       | Doctor’s phone number |       |
| Please note any medical or other preparations (e. g. multivitamins, herbs etc.) and daily dosage |       |
| Have you ever been in counselling or psychotherapy? | [ ]  Yes [ ]  No | If yes, how long? |       |
| With what results? |       |
| Have you even used hypnosis? | [ ]  Yes [ ]  No | If yes, under what conditions? |       |
| With what results? |       |

**THERAPY INFORMATION**

|  |  |
| --- | --- |
| What SPECIFIC issue/situation brings you here? *Please summarise briefly in your own words* |       |
| What would you say is your MAIN concern at this time? |       |
| What would you be willing to let go of, or give up, to handle this concern, condition or situation? |       |
| What would you NOT be willing to give up to handle this concern, condition or situation? |       |
| Have you ever seen anyone hypnotised? | [ ]  Yes [ ]  No |
| If yes, how did you feel about that? |       |
| What was the response of others around you to the hypnosis? |       |
| Please describe TWO of your favourite scenes or places, which symbolise to you good feelings such as peace, harmony, tranquillity, contentment or relaxation. *To aid clarity please focus on sight, sound, smells, textures, movement, taste, feelings on your skin (wind, clothing etc.) and or any other sensations or emotions each scene evokes.* |       |

**BACKGROUND INFORMATION**

To help us make the most of the time available to you, please complete each of the items below.
If an item does not apply enter N/A. *Your through and honest responses will help provide more efficient and effective service to you.*

|  |  |  |  |
| --- | --- | --- | --- |
| Any conditions requiring hospitalisation or outpatient treatment you have had over the past three years. |       | Length of stay |       |
| Outcomes |       |
| Any current treatments | [ ]  Yes [ ]  No | For which conditions? |       |
| Supporting Doctor’s name |       | Doctor’s phone number |       |
| Doctor’s location |       |

Your family history may also be of value, please check any of the following that apply to blood relatives and give the relation to you.

|  |  |  |  |
| --- | --- | --- | --- |
| Problem drinking or alcoholism | [ ]  Yes [ ]  No | Substance abuse or drug addiction | [ ]  Yes [ ]  No |
| Bouts of rage | [ ]  Yes [ ]  No | Suicide or frequent attempts | [ ]  Yes [ ]  No |
| Depression or other emotional conditions | [ ]  Yes [ ]  No | Any conditions requiring institutionalization |       |
| Do you smoke or use tobacco? | [ ]  Yes [ ]  No | How much do you consume on a good day? |       |
| How much on a difficult day? |       |
| Do you use alcohol? | [ ]  Yes [ ]  No | How much do you consume on a good day? |       |
| How much on a difficult day? |       |
| In what form? |       |
| Do you use mind altering substances?*(Valium, cannabis, diet pills etc.)* |       | How much do you consume on a good day? |       |
| How much on a difficult day? |       |
| Name of substance(s) |       |
| How many good days would you have in a week? |       | How many difficult days per week? |       |

**COMMENTS**

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| --- |
|       |

*Please enter your name to complete the sentence.*I,      , confirm that the given information is correct to my best knowledge.