**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.