SHORT ROAD TO HOPE

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	- please select -	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?			

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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			

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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

Please enter your name to complete the sentence.

I, , confirm that the given information is correct to my best knowledge.