CLIENT INTAKE FORM – Christchurch Hypnosis

Name: _____

Today's Date: _____
Date of Birth:_____ Age _____ Gender: M F Race _____
Address: _____
Employer: _____
City: _____ Post Code: _____
Day Phone_____ Home Phone: _____Cell Phone: _____
E-mail:_____
Marital Status: _____Married _____Single _____Divorced _____Widow
Name of Spouse:_____
Day Phone_____ Home Phone:_____ Cell hone:_____
Names and Ages of Children:
_____ Age ___ _____ Age ___
_____ Age ___ _____ Age ___
_____ Age ___ _____ Age ___
List favorite colors: _____
List favorite places: _____
List any fears or phobias: _____
Do you suffer any compulsive tendencies_____
Do you: _____ Smoke _____ Use Drugs _____ Drink Religious Preference: _____
List any current health problems _____
_____
List any medications that you are taking:
_____
List your most important life time goals_____
_____
List your past-time hobbies_____
Current Occupation: _____
Do you enjoy your work: _____
List three things that you would like to do better or improve:
_____
_____
If you could be, do, have or become anything, what would you wish for?
_____
Why are you seeking Hypnotherapy?
_____
How did you hear about this office_____
_____
Are you currently suffering from: (Select all that apply)
__nervousness __inability to relax __sleeplessness __sexual dysfunction __ nail biting __compulsive tendencies __nightmares __poor health __cigarette smoking __ alcohol abuse __drug abuse compulsive overeating __serious eating disorder __codependency __inability to focus attention __poor memory __marital problems __recent divorce __war trauma __current illness __teeth grinding __lack of energy __death of a loved one __childhood trauma __fear of heights __poor self-esteem __abusive home situation __abusive work situation __abusive relations of any source __ lack of success __sexual abuse
Other _____
_____
One of the things I feel guilty of is:
_____
I am happiest when: _____
_____
If I were not afraid to be myself I would _____
_____
I get so angry when_____
I am most saddened by _____
_____

CLIENT INTAKE FORM – Christchurch Hypnosis

Name: _____

All my life _____
_____
Ever since I was a child _____
_____
One of the ways I could help myself but I just don't is _____
_____
It is hard for me to admit _____
_____
I am a person who _____
A mother should _____
A father should _____
A friend should _____
A true friend should _____
What behaviors seem to get in your way of happiness _____
_____
_____
What would you like to start doing_____
_____
_____
What would you like to do more often_____
_____
What would you like to do less of_____
_____
What makes you laugh_____
_____
What makes you cry_____
_____
Do you cry a lot _____If so how much_____
What makes you happy_____
What makes you sad _____
What makes you mad_____
What makes you frightened_____
What do you see or imagine your life being like in 6 months to a year_____
_____
_____
What motivates you_____
Who motivates you the most_____
In one sentence describe your life _____
In one sentence describe your problems _____
One of the things I feel proud of is_____
What is the most important to you in your life_____
What is the most important part of a relationship to you_____
Do you observe any religious or meditative practices _____Yes _____ No
Explain any other negative conditions affecting you_____
_____
List any additional needs or concerns _____
_____

Stress Level Profile:
Read each statement below and circle the number to the right of it that best represents yourself and your behavior at this time**. 1- not at all 2- slightly 3- moderately 4- very much**

1	I often lose my appetite or eat when I am not hungry	1 2 3 4
2	My decisions seem to be more impulsive than planned, I tend to feel more unsure about my choices and often change my mind	1 2 3 4
3	The muscles in my neck, back and stomach frequently get tense.	1 2 3 4

Name: _____

4	It seems that I have thoughts and feelings about my problems that run through my mind most of the time	1 2 3 4
5	I have a hard time getting to sleep, and I wake up often or feel tired	1 2 3 4
6	I feel the urge to cry or get away from my problems	1 2 3 4
7	I tend to let anger build up and then explosively release my temper in some aggressive way or destructive way	1 2 3 4
8	I have nervous habits (tapping my fingers, shaking my leg, pulling my hair, scratching, wringing my hands and etc)	1 2 3 4
9	I often feel fatigued, even when I have not been doing physical work	1 2 3 4
10	I have regular problems with constipation, diarrhea, upset stomach or …….	1 2 3 4
11	I tend to not meet my expectations either because they are unrealistic or I have taken on more than I can handle	1 2 3 4
12	I periodically lose my interest in sex	1 2 3 4
13	My anger gets aroused easily	1 2 3 4
14	I often have bad unhappy dreams or nightmares	1 2 3 4
15	I tend to spend a great deal of time worrying about things	1 2 3 4
16	My use of alcohol, coffee, smoking or use of drugs has increased	1 2 3 4
17	I feel anxious, often without any reason that I can identify	1 2 3 4
18	I conversation my speech tends to be week, rapid, broken or tense	1 2 3 4
19	I tend to be short tempered and irritable with people	1 2 3 4
20	Delays, even ordinary ones, make me fiercely impatient	1 2 3 4

Signature: _____Date:_____

NOTES – COMMENTS: