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# Client Intake Form

## Personal Data Record

Name (first/last): ______________________________ Date: ________________

Parent/Legal Guardian (if under 18): ________________________________________

Address: ________________________________________________________

City: ____________________________ State: ________ Zip: ______________

Phone: __________________ ❑ Home ❑ Mobile Date of Birth: ______________

Email (Is this a private email?): ______________________________________

Gender Identity: ______________ Cultural Considerations: ______________________

Hobbies/Interests: ______________________________________________

Name and Phone Number of Close Friend or Relative to Contact in an Emergency:

________________________________________________________________

Name Relationship to You Phone

How did you hear about my services? ____________________________________

Have you ever been hypnotized before? ❑ Yes ❑ No

If yes, what was the reason and outcome of your previous experience? ____________________

________________________________________________________________

________________________________________________________________

Please list what you intend to accomplish through the use of our services.

________________________________________________________________

________________________________________________________________

________________________________________________________________

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# Life History Questionnaire

*The purpose of this questionnaire is to obtain a comprehensive picture of your background. By completing these questions, as fully and as accurately as you can, you will provide your therapist with important information, without using your actual therapy time. Please share with me whatever information you feel might be helpful in our work together. Your answers will remain confidential.*

## General Health

How would you rate your current physical health?

Poor _____ Unsatisfactory _____ Satisfactory _____ Good _____ Excellent ____

How would you rate your current sleeping habits?

Poor _____ Unsatisfactory _____ Satisfactory _____ Good _____ Excellent _____

Describe your sleep schedule and any sleep issues. ______________________________________________

______________________________________________________________________________

Have you been having any notable dreams? _________________________________________________

______________________________________________________________________________

How many times a week do you generally exercise? ____________________________________________

What types of exercise do you participate in?_________________________________________________

Please describe any difficulties with your weight, appetite, or eating patterns: ___________________________

______________________________________________________________________________

______________________________________________________________________________

Do you have any current and chronic medical issues/challenges? ____________________________________

______________________________________________________________________________

Have you ever been hospitalized for medical or mental illness? If so, list when, where & reason:

______________________________________________________________________________

______________________________________________________________________________

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## Life History Questionnaire

Please list any prescription or over-the-counter medications, including dosages and frequency.

______________________________________________________________________________

______________________________________________________________________________

Your medical care team: Doctors' name(s)/Phone numbers: ___________________________________

______________________________________________________________________________

______________________________________________________________________________

If you enter treatment with me, may I communicate with your medical doctor(s) to coordinate your treatment?

❑ Yes ❑ No ❑ Maybe (Within Limits)

Do you drink alcohol or use recreational drugs? If so, what kind and how often? ______________________

______________________________________________________________________________

Do you or anyone close to you consider your use to be a problem? ❑ Yes ❑ No ❑ Debatable

## Present Relationships

Are you currently partnered or in a relationship? ❑ Yes ❑ No How long? ____________________

If yes, how do you get along with your partner or spouse? ____________________________________

______________________________________________________________________________

Do you have children/grandchildren? If yes, what are their ages? _________________________________

______________________________________________________________________________

How do you get along with your children/grandchildren? ______________________________________

______________________________________________________________________________

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# Life History Questionnaire

Briefly describe any other important relationships in your life and how satisfied you are with how they are going. ______________________________________________

______________________________________________

______________________________________________

## Childhood & Family

Where were you born? Where did you grow up and live most of your childhood? ______________

______________________________________________

Briefly describe your family of origin (parents, siblings, etc.) and your childhood: ______________

______________________________________________

Parents? (Alive, divorced, how is your relationship with them?) ______________________

______________________________________________

Siblings? (Close, distant, how is your relationship with them?) ______________________

______________________________________________

Did you have serious illnesses/injuries OR physical/emotional trauma as a child? If so, and at what age?

______________________________________________

## Education & Employment

What was the highest grade of education you completed? ______________________

Are you currently employed? ❑ Yes ❑ No Are you currently a student? ❑ Yes ❑ No

Describe your current occupation/previous occupation(s). ______________________

______________________________________________

Employer: ______________________ Length of time with this employer: __________

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# Life History Questionnaire

## Past Psychological/Psychiatric Treatment

Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services?

Please indicate which type of treatment: ❑ Inpatient ❑ Outpatient ❑ Both ❑ Other: _______________

If yes, please indicate details:_______________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

Have you ever taken medications for psychiatric or emotional problems? If yes, please indicate type, duration, results: ________________________________________________________________________________

_____________________________________________________________________________________

Do you have any family history of psychological/psychiatric disorders? If yes, please describe. _______________

_____________________________________________________________________________________

_____________________________________________________________________________________

Have you been suicidal in the past month? ❑ Yes ❑ No

Have you ever had thoughts of taking your life? ❑ Yes ❑ No

Have you ever acted on these thoughts? ❑ Yes ❑ No

If yes, please describe what happened: ____________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

Has anyone in your family taken their own life or attempted suicide? If yes, please describe. _________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

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# Life History Questionnaire

**Please check any of the following that have been bothering you lately:**

| | | | | | |
|---|---|---|---|---|---|
| ❑ | Abused as Child | ❑ | Agoraphobia | ❑ | Alcohol Use |
| ❑ | Ambition | ❑ | Anger | ❑ | Anger Management |
| ❑ | Anxiety/Stress | ❑ | Appetite | ❑ | Being a Parent |
| ❑ | Bladder/Bowel Issues | ❑ | Career Choices | ❑ | Children |
| ❑ | Compulsions | ❑ | Compulsivity | ❑ | Concentration |
| ❑ | Confidence | ❑ | COVID-19 Fears | ❑ | COVID-19 Losses |
| ❑ | COVID-19 Recovery | ❑ | Depression | ❑ | Divorce |
| ❑ | Drug Use/Abuse | ❑ | Eating Problem(s) | ❑ | Education |
| ❑ | Energy (High/Low) | ❑ | Extreme Fatigue | ❑ | Family Member (Dementia) |
| ❑ | Fears/Phobias | ❑ | Feeling Suicidal | ❑ | Finances |
| ❑ | Friends | ❑ | Grief | ❑ | Guilt |
| ❑ | Headaches | ❑ | Health Problems | ❑ | Inferiority Feelings |
| ❑ | Insomnia | ❑ | Loneliness | ❑ | Making Decisions |
| ❑ | Marriage | ❑ | Memory | ❑ | Nervousness |
| ❑ | Nightmares | ❑ | Obsessive Thinking | ❑ | Overweight |
| ❑ | Painful Thoughts | ❑ | Panic Attacks | ❑ | Physical Pain |
| ❑ | Relationships | ❑ | Sadness | ❑ | Self-Esteem |
| ❑ | Self-Harm (Cutting, etc) | ❑ | Separation | ❑ | Sexual Problems |
| ❑ | Short Temper | ❑ | Shyness | ❑ | Sleep |
| ❑ | Suicidal Thoughts | ❑ | Weight Issues | ❑ | Work |

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# Life History Questionnaire

**Please indicate (check) how the issue(s) for which you are seeking treatment are affecting the following areas of your life:**

Use the following scale:

1. No Effect
2. Little Effect
3. Some Effect
4. Much Effect
5. Significant Effect
6. Doesn't Apply

| Areas of Life Effected | 1<br>No Effect | 2<br>Little Effect | 3<br>Some Effect | 4<br>Much Effect | 5<br>Significant Effect | 6<br>Doesn't Apply |
|---|---|---|---|---|---|---|
| Marriage/Relationship | | | | | | |
| Family | | | | | | |
| Job/School Performance | | | | | | |
| Friendships | | | | | | |
| Financial Situation | | | | | | |
| Physical Health | | | | | | |
| Anxiety Level | | | | | | |
| Mood | | | | | | |
| Eating Habits | | | | | | |
| Sleeping Habits | | | | | | |
| Sexual Functioning | | | | | | |
| Alcohol/Drug Use | | | | | | |
| Ability to Concentrate | | | | | | |
| Ability to Control Anger | | | | | | |

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# Life History Questionnaire

## More About You

How would you describe important aspects of your cultural/ethnic identity that would be important for me to consider as your hypnotherapist? ____________________________________________

____________________________________________

____________________________________________

Do you consider yourself spiritual or religious? If so, describe your spirituality/faith and your level of participation in a faith-based group. ____________________________________________

____________________________________________

____________________________________________

What do you consider your greatest strengths/ sources of resilience? ____________________________

____________________________________________

____________________________________________

Is there anything else that is important for me as your therapist to know about and that you have not written about on any of these forms? ____________________________________________

____________________________________________

____________________________________________

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