Dr. Kroner's Client Intake Form

Hypnotherapy, Neuro-Linguistic Programming, Time Line Therapy, Confidence Coaching, Career Path Discovery, Special Needs Parent Support, Biofeedback

- Please fill in the information below and bring it with you to your first session or scan it and email it to drshannonkroner@gmail.com
- This Intake Form will take about 20-30 minutes to complete.
- Please fill it out as completely as possible. The more info I have, the better your results.
- **All information is strictly CONFIDENTIAL and will not be released except upon your written request.**

PERSONAL INFORMATION

Name: _____ Date: _____

Address:

_____

Home Phone: _____ May we leave a message? □ Yes □ No

Cell/Work/Other Phone: _____ May we leave a message? □ Yes □ No

Email: _____

**Please note: Email correspondence is not considered to be a confidential medium of communication.*

DOB: _____ Age: _____ Gender: _____

Martial Status:

□ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

Referred By (if any):

_____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Number: _____

GENERAL AND MENTAL HEALTH INFORMATION

What's the issue that you're ready for me to help you resolve? _____

_____

_____

_____

_____

Do you consider it to be more of a problem or a goal?

- Problem
- Goal

How big of an issue is it?

- Major
- Serious
- Moderate
- Minor

What area(s) of your life does it involve?

- Self Development
- Health & Fitness
- Career
- Relationships
- Family
- Spirituality

Select any of the following that applies to your issue:

- I need to reduce stress.
- I need to control a habit.
- I need to experience a personal breakthrough.
- I need to achieve a major goal.
- I need to transform my life.

Do you want to resolve it,
or do you 'want to want' to resolve it?

- I want to resolve it
- I want to want' to resolve it

What has this issue cost you so far in your life (time, money, suffering, lost opportunities, sacrifice, etc)?

- A lot
- A little
- Not much
- Nothing

What has been this issue's biggest cost to you? _____

If left unresolved, what could this issue end up costing you over the next 10 years?

- A lot
- A little
- Not much
- Nothing

Are you looking for a quick fix, or are you ready to sincerely commit to resolving this issue?

- Looking for a quick fix
- Ready to sincerely commit to resolving it

NOTE: The length of our average recommended Coaching Program is between 1 to 2 months.

How committed are you to resolving this issue?

- 100%
- 75%
- 50%
- 25%

What's the MINIMUM length of time you're willing to invest toward resolving this issue?

- 1-2 months
- 3-4 months
- As long as it takes

What's the MAXIMUM length of time you're willing to invest toward resolving this issue?

- 1-2 months
- 3-4 months
- As long as it takes

What have you previously invested in to help you with this? _____

What characteristic(s) are most important to you in a coach?

- Inspirational
- Encouraging
- Tells it like it is
- Humorous
- Serious
- Easygoing
- Authoritative
- Unconventional
- Flexible
- Kind
- Tough
- Curious
- Creative
- Knowledgeable
- Wise

How would you rate your ability to follow instructions?

- Above average
- Average
- Below average

What's most important to you about resolving your issue?

What are your main strengths? _____

What, if any, are your limitations? _____

List 5 or more of your most meaningful accomplishments. _____

HISTORY

Have you previously received any type of help for your current issue (psychotherapy, psychiatric services, coaching, hypnotherapy, etc.)?

□ No □ Yes, previous therapist/practitioner/coach:
_____

Are you currently taking any prescription medication? □ Yes □ No
If yes, please list:
_____

_____

Have you ever been prescribed psychiatric medication? □ Yes □ No
If yes, please list and provide dates:
_____

_____

HEALTH AND FITNESS

Name of Primary Care Physician _____

Physician's Phone Number _____

Please list any current treatment you're receiving from health care providers:

_____

Please list any current medications and dosages: _____

_____

Hours of sleep required? _____

What is your normal bedtime? _____

Do you have difficulty staying asleep?

- o No
- o Yes

Which of the following physical complaints currently apply to you?

- o Aches and pains
- o Blurred vision

- Chronic indigestion
- Cold hands and feet
- Dizziness
- Drowsiness
- Excessive sweating
- Fainting or blackouts
- Fatigue or exhaustion
- Hand tremors
- Headaches
- Heart palpitations
- Internal trembling
- Itching
- Joint pain
- Light or noise sensitivity
- Muscle twitching or cramps
- Numbness
- Over-talkative
- Premenstrual symptoms
- Weakness

Which of the following have you noticed as related to your current dietary habits?

- Abnormal craving for sweets
- Afternoon cravings for sweets or caffeine
- Eat when nervous
- Family history of diabetes or hypoglycemia
- Fatigue is relieved by eating
- Feel faint if meals are delayed
- Frequently skip breakfast
- Get shaky if hungry
- Heart palpitates if meals are missed or delayed
- Irritable before meals
- Must have morning caffeine
- Regular alcohol consumption
- Sleepy after meals
- Symptoms leave after breakfast
- Very hungry between meals

Which of the following do you consume on a REGULAR basis?

- Coffee
- Regular soft drinks (Coke…)
- Diet soft drinks (Diet Coke…)
- Energy drinks (Red Bull…)
- Pre-workout energy formula
- Artificial sweeteners (Equal, Splenda…)
- Sugar, agave and/ or maple syrup
- Cookies, cake, pastries, donuts, muffins and/or pies
- Candy and/or candy bars
- Ice cream and/or frozen desserts
- Chocolate
- White rice
- White flour-based products (white bread, pasta, noodles…)
- Whole grain products (whole wheat)
- Fruit juices (orange, grape, apple…)
- Smoothies
- Dairy products (milk, cheese, yogurt…)
- Herbal tea

- Fresh vegetables
- Fresh fruits
- Animal protein (beef, poultry, pork, seafood, eggs)
- Plant-based protein
- Nuts and seeds
- Protein bars
- Nutritional supplements (vitamins, herbs…)
- Fast food
- Alcohol (beer, wine, hard liquor…)

Which of the following emotional complaints currently apply to you?

- Antisocial behavior
- Circular thinking
- Constant worrying
- Difficulty concentrating
- Emotional fragility
- Feeling "on edge"
- Feeling of a loss of control
- Feelings of inadequacy
- Forgetfulness
- Highly emotional
- Indecisiveness
- Irritability
- Lack of sex drive
- Low tolerance for stress
- Magnifying insignificant events
- Mental confusion
- Moodiness
- Negative thoughts and attitudes
- Nervousness
- Nightmares
- Phobias or fears
- Reduced initiative
- Restlessness
- Temper tantrums

Which of the following have ever applied to you at any time during your life?

- Panic or anxiety attacks
- Easily startled
- Cry easily for no reason
- Frequent crying
- Sleeping too much
- Periods of daily sadness lasting more than two weeks
- Can't stop remembering upsetting past events
- Worry something's wrong with my body
- Throw up to lose weight
- Use laxatives or exercise excessively to lose weight
- Often feel like an outsider
- Frequent arguments with others
- Sexual problems
- Difficulty controlling temper
- Break things sometimes
- Thoughts of killing/hurting others
- Thoughts of killing/hurting myself
- Attempts to kill/hurt myself
- Hallucinations
- Hear voices

How would you rate your current physical health?

- o Unsatisfactory
- o Satisfactory
- o Good Very
- o Good

Please list any specific health problems you are currently experiencing:

_____

_____

How many times per week do you generally exercise? _____

What types of exercise do you participate in? _____

Please list any difficulties you experience with your appetite or eating problems: _____

_____

Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes

If yes, for approximately how long? _____

Are you currently experiencing anxiety, panics attacks or have any phobias? □ No □ Yes

If yes, when did you begin experiencing this? _____

Are you currently experiencing any chronic pain? □ No □ Yes
If yes, please describe:

_____

How often do you drink alcohol? □ Daily □ Weekly □ Monthly □ Infrequently

Do you use drugs/How often? □ Daily □ Weekly □ Monthly □ Infrequently

Are you currently in a romantic relationship?
If yes, for how long?

_____

On a scale of 1-10 (with 1 being poor and 10 being exceptional), how would you rate your relationship?

_____

What significant life changes or stressful events have you experienced recently? _____

_____

_____

FAMILY MENTAL HEALTH HISTORY

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (e.g. father, grandmother, uncle, etc.)

- Alcohol/Substance Abuse _____
- Anxiety_____
- Depression_____
- Domestic Violence _____
- Suicide Attempts _____
- Eating Disorders _____
- Obesity_____
- OCD_____
- Behavior Schizophrenia_____

Are you currently employed?

- Yes
- No

Additional Information

If yes, what is your current employment situation? _____

_____

Do you enjoy your work? Is there anything stressful about your current work?_____

RECENT LIFE CHANGES

Have you experiences any of the following:

- An illness or injury which was very serious

- An illness or injury which was moderately severe
- An illness or injury which was less serious

Home / Family Changes

- Change in residence
- Major change in living conditions
- Change in family gatherings
- Major change in health or behavior of family member
- Marriage
- Pregnancy
- Miscarriage or abortion
- Birth or adoption of a new child
- Partner begins or stops work
- Change in arguments with partner
- Problems with relatives or in-laws
- Parents divorce
- A parent remarries
- Separation from partner due to work or relationship difficulties
- Child leaves home
- Relative moves in with you
- Divorce or major breakup
- Birth of a grandchild
- Death of a partner
- Death of a child
- Death of a parent or sibling
- Death of a close friend

Financial Changes

- Major loss of income
- Major increase in income
- Loss or damage to personal property
- Major purchase
- Credit difficulties

Work Changes

- Change to a new type of work
- Change in your work conditions
- Change in your work responsibilities
- Taking courses to help you
- Troubles at work
- Major business readjustment
- Loss of your job
- Retirement

Personal / Social Changes

- Change in personal habits
- Beginning or ending school
- Change in school or college
- Change in political beliefs
- Change in religious beliefs
- Change in school activities
- Vacation
- Birth or adoption of a new child
- Partner begins or stops work
- Change in arguments with partner
- New, close, personal relationship
- Engagement to marry

- Personal relationship problems
- Sexual difficulties
- An accident
- Minor violation of the law
- Being held in jail
- Substance abuse or chemical dependency
- Major decision about your future
- Major personal achievement

What do you consider to be some of your strengths?

_____

_____

_____

What do you consider to be some of your weaknesses?

_____

_____

_____

What would you like to accomplish out of your time in therapy?

_____

_____

_____

- **We have a 24-Hour Cancellation / Rescheduling Policy:**
- Cancelled, rescheduled or missed appointments with **less than 24 hours notice** will result in your being charged a fee of **$100**.
- When a client gives us last minute notice—or no notice at all—we're usually left with insufficient time to fill the vacant time slot with another client in need of it.

Thank you for your understanding and cooperation.

☐ Please check the box if you have filled out the intake and understand and agree to the 24-Hour Cancellation / Rescheduling Policy described above.