

General Checklist for Therapy Sessions

(Private and Confidential)

Your Name:

Date:

Client Identifier (to maintain confidentiality use initials only):

Presenting Symptom:

Session number:

You are required, with the consent of your client, to note whether you have achieved the following (where appropriate) during your therapy session with your client.

Part 1 (Case History)

1. Rapport

- a. Did the therapist make good eye contact?
- b. Did the therapist ask how they can refer to the client?
- c. Was the therapist sufficiently relaxed and attentive?
- d. Did the therapist appear sufficiently interested?
- e. Did the therapist use open-ended questioning?

2. Personal interests

- a. Did the therapist ask about hobbies, things the client enjoys doing, holidays etc?
- b. Did the therapist find out what their client does to relax?
- c. Did the therapist explore their client's attitude toward their career?
- d. Did the therapist find out whether their client partakes in exercise

3. Family

- a. Did the therapist ask about their client's family?
- b. Did the therapist explore the clients relationship with their current partner, children, siblings, parents?

4. Health

- a. Did the therapist ask about alcohol consumption?
- b. Did the therapist discover whether their client is a smoker/non-smoker?
- c. Did the therapist explore whether their client takes recreational drugs?

5. Safety

- a. Did the therapist ask permission to contact the client's doctor if necessary?
- b. Has the therapist asked whether their client has talked to their doctor about their presenting symptom?
- c. Did the therapist check for contraindications?

6. *Medical history*

- a. Did the therapist ask about current and past medication and why they are taking/took it?
- b. Has the therapist explored the client's past psychiatric history?
- c. Has the therapist asked about any current and past physical ailments?

7. *Previous therapies*

- a. Has the therapist asked about previous attempts at resolving the client's presenting symptom?
- b. Has the therapist asked about past therapies, what they were (including hypnotherapy) and why they used them?

8. *Client's knowledge of hypnosis*

- a. Did the therapist check whether the client has knowledge or previous experience with hypnosis/hypnotherapy?
- b. Has the therapist explored the client's expectations for hypnotherapy?
- c. Has the therapist discussed myths and misconceptions surrounding hypnosis/hypnotherapy?

9. *Meta model*

- a. Where appropriate, did the therapist use meta modelling to explore any of the above?

10. *Client's perception of the problem*

- a. Did the therapist explore when the problem first started?
- b. Did the therapist explore what was happening in the client's life at that time?
- c. Did the therapist explore whether there is a family history of the symptom?
- d. Did the therapist explore how the client has tried to resolve/handle the symptom in the past and what the outcome was?
- e. Did the therapist explore whether the symptom had ever been in remission?
- f. If the symptom has previously been in remission, Did the therapist explore what was happening the client's life at that time?
- g. If the symptom has previously been in remission, did the therapist explore why the symptom reappeared?
- h. Has the therapist used meta modelling to explore the above?

11. *How the problem affects the client's life*

- a. Did the therapist explore how the symptom is expressed?
- b. Did the therapist explore how the symptom is currently affecting the client's life?
- c. Did the therapist explore what makes the symptom worse?
- d. Did the therapist explore what makes the symptom better?
- e. Did the therapist explore what the attitude of significant others is towards the symptom?
- f. Has the therapist used meta modelling to explore the above?

12. Goal setting

- a. Has the therapist explored a SMART goal with the client?
- b. Has the therapist explored the way the client wants to be thinking, feeling, appearing when they have achieved their goal
- c. Has the therapist used meta modelling to explore the above?
- d. On sessions other than the first, has the therapist checked that the goal is still the same as originally set?

Part 2 (Script Delivery)

1. Voice

- a. Did the therapist make use of their tone of voice?
- b. Did the therapist pace the delivery of suggestions?
- c. Was the therapists voice congruent with the delivery of the script?

2. Rapport

- a. Was the therapist sufficiently relaxed and attentive?
- b. Did the therapist observe the client during script delivery
- c. Did the therapist manipulate distractions?

3. Technique

- a. Was the therapist flexible and able to adapt the therapy approach to the client's case history information

4. Safety

- a. Did the therapist check for contraindications?
- b. Did the therapist ask for permission to touch a specified area prior to the induction of trance (if the technique requires touch)?
- c. Did the therapist ask warn the client that they were about to touch a specified area prior to touching (if the technique requires touch)?
- d. Did the therapist ensure that the client was fully awake at the end of the session?
- e. Did the therapist include *“every part of you back here with me in the present ... all normal sensations returned to your limbs”* during awakening?

Consent from client
(initials only)

Therapist's signature

Please leave comments (If any):
