Clinical Intake Form

A Guide for the Therapist Only

Client Case Number: _____

*To create the **Client Case Number**, go to your **Client Contact Log** and enter a session for this client. The Client Case Number will automatically be generated. These are unique to each client and help preserve their anonymity. Please remember to avoid using any identifiable client information on this form or in your log.*

Client Information:

Age: _____

Gender Identity/Sexual Orientation: _____

_____

Chief Concern

What is the main concern that has brought you in to see me:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Presenting Issue(s): (Client View)

1. _____
2. _____
3. _____
4. _____
5. _____

Life Impact:

How has _____ effected your life?

Onset:

Do you recall the first time _____ happened?

Have the symptoms reoccurred or gotten worse recently? _____

What made you call now? _____

Triggers/Stressors Related to the Presenting Problem:

_____

_____

_____

_____

Patterns:

_____

_____

_____

_____

Automatic or Unconscious Thoughts: (If they have an automatic/unconscious thought, what do they experience first when an incident occurs, or are they triggered/stressed? Do they experience a feeling first or the thought?)

_____

_____

_____

_____

_____

Defensive Mechanisms:

_____

_____

_____

_____

_____

Coping Mechanisms:

_____

_____

_____

_____

_____

Therapy History

Prior to today, have you tried any other methods (counseling, self-help, meditation, etc.) to help you with _____?

(If "yes") Did you find that _____ helped and if so, how did you benefit from _____?

Therapeutic Goal Client View: (If I had a magic wand, and you no longer had _____, what would your life look like and what would this mean for you?)

_____

_____

_____

_____

_____

Positive Words and Phrases: (How they envision themselves/their life without the habit that is no longer serving them?)

_____

_____

_____

_____

_____

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 _____

Are you diabetic or do you have a family history of diabetes? _____

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:

_____

What does your daily/weekly intake of sugar and carbs look like?

_____

Do you have any **current** or **chronic** medical issues/challenges?

_____

_____

Are you taking any **prescription** or **over-the-counter** medications? If so, what is the dosage amount?

_____

Who is the prescribing Doctor for your medications? 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)

Mental Status

Appearance: (Grooming, dress, facial expression, physical appearance, etc.)

_____

_____

Behavior: (Dramatic, angry, shy, withdrawn, hostile, passive, childlike, etc.)

_____

_____

Attitude Toward Hypnotherapist: (Open, aggressive, passive, guarded, manipulative, etc.)

_____

_____

Mood: (Client's Report)

_____

_____

Speech: (Volume, pitch, rhythm, etc.)

_____

_____

Repetitive Words, Phrases, or Metaphors:

_____

_____

_____

Body Language:

- Crossed Arms and/or Legs _____
- Slouching in Chair _____
- Tapping Foot or Shaking Leg _____
- Sitting Up Straight _____
- Other _____

Eye Movement/Contact:

- Makes Eye Contact _____ Doesn't Make Eye Contact _____ Looks Down _____
- Upper Left _____
- Lateral Left _____
- Lower Left _____
- Upper Right _____
- Lateral Right _____
- Lower Right _____

Incongruencies: (Are they laughing while making statements with negative words like; angry, depressed, sad, afraid.)

_____

_____

_____

_____

Focus: (Are they able to focus on one topic or are they all over the place jumping from one topic to the next.)

_____

_____

_____

_____

Suicidal Ideation: (Ideation/fantasies, present and/or past)

_____

_____

_____

_____

Countertransference Issues:

_____

_____

_____

_____

Sleep Patterns and Dreams:

Describe your sleep schedule and any sleep issues.

_____

_____

_____

_____

Have you been having any notable dreams?

_____

_____

_____

_____

Relationships

Marital Status? _____ Are you in a current relationship? Yes _____ No _____ Describe.

_____

_____

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

_____

_____

Children (Ages)?

_____

Who do the children live with?

_____

_____

Parents? (Alive, divorced, how is the relationship to their parents?)

_____

_____

Living situation. (House, apartment, rent, own, parents, homeless, etc.)

_____

_____

Briefly describe ***any other*** important relationships in your life. Are you satisfied with how they are going?

_____

_____

Childhood and Education

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

_____

_____

_____

Did you have serious illnesses/injuries **OR** physical/emotional trauma as a child?

_____

_____

_____

_____

Education Details:

_____

_____

_____

_____

Occupation/Previous Occupation(s):

_____

_____

_____

_____

Employer: _____ Length of time with this employer: _____

Past Psychological/Psychiatric Treatment

Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services? Yes _____ No _____

Please indicate which type of treatment: Inpatient _____ Outpatient _____ Both _____

If yes, please indicate details: _____

_____

Are you or have you ever taken medications for psychiatric or emotional problems?
Yes _____ No _____

If yes, please indicate type, duration, results: _____

_____

Do you have any **family history** of psychological/psychiatric disorders? Yes _____ No _____

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? Yes _____ No _____

If yes, please describe: _____

_____

_____

Please tell me if any of the following has 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

Stress

Using a scale from 1-6, *(go over scale),* please tell me how the issue for which you are seeking treatment are affecting the following areas of your life:

Use the following scale to measure the Effect/Stress:

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

Areas of Life Effected	**1** No Effect	**2** Little Effect	**3** Some Effect	**4** Much Effect	**5** Significant Effect	**6** 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						

Substance Use

Do you currently consume alcohol and/or marijuana? Yes _____ No _____

If yes, on average how many drink per occasion do you consume? _____

How many days per week do you consume alcohol and/or marijuana? _____

Do you have a history of problematic use of alcohol and/or marijuana? Yes _____ No _____

Have family members or friends expressed concern about your drinking or drug use?
Yes _____ No _____

Do you currently use non-prescribed drugs or street drugs? Yes _____ No _____

Do you have a history of problematic use of prescription or non-prescription drugs?
Yes _____ No _____

Do you have a family history of alcohol/drug problems? Yes _____ No _____

If yes, please describe:_____

_____

_____

_____

Do you smoke or use other tobacco products? Yes _____ No _____

If yes, would you like help in quitting smoking? Yes _____ No _____Perhaps _____

Do you feel that you are in danger? Yes _____ No _____

If yes, please explain: _____

_____

_____

_____

More About Client

What normally brings you joy?

_____

_____

_____

_____

Have you recently had difficulty experiencing that sense of joy? Yes _____ No _____

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

_____

_____

_____

_____

_____

_____

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

_____

_____

_____

_____

_____

_____

Therapeutic Plan/Therapists Notes to Self

What do you see as the short-term strategy, first 6 sessions?

_____

What do you see as a long-term strategy, after the first 6 sessions?

_____

What information do you think you're missing?

_____

What are your concerns about this client?

_____

What is your intuition telling you about this client?

_____

Do you think that client is being honest with you?

_____

Do you think the presenting issue is really the issue they are here for and if not, what does your intuition tell you?

_____

What would you like to see as the ultimate outcome for this client? What future vision do you have for them?

_____

_____

_____

_____

Hypnotherapy

E&P Hypnotic Suggestibility Type and %:_____

E&P Sexuality Scale Type and %: _____

Suggestibility Testing and Observations:

_____

Primary Hypnotic Induction and Observations:

_____

Deepener(s) Used:

_____

Key Hypnotic Suggestions and/or Therapeutic Imageries:

_____

Anchors Used/Anchor Words:

_____

Abreactions in Hypnosis:

_____

Client Feedback on Hypnosis:

_____

General Notations and/or Ideas for Next Session:

_____

Therapeutic Goals (Hypnotherapist View)**:**

1. _____
2. _____
3. _____
4. _____
5. _____

Client Homework:

_____

_____

_____

_____

_____

My Homework:

_____

_____

_____

_____

_____

Other Important Information:

_____

_____

_____

_____

_____

_____

_____

_____