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# Clinical Interview Intake Form

Date: _____ Time: _____

Name: _____
FIRST MIDDLE LAST

Address: _____

_____

Preferred Contact Telephone# _(_____)_____

Email: _____

Date Of Birth: _____/_____/_____ Age: _____ Gender: ____M ____F

What do you want to accomplish with hypnosis today:
____ Stress and Anxiety Management
____ True Non-Smoker
____ Weight Loss
____ Chemotherapy Relief
____ Overcome Fears - Specify: _____
____ Test Taking
____ Medical Condition - Specify:_____
____ Pain Management
____ Other - Specify: _____

What is your prior experience with hypnosis:
____ None
____ Have been hypnotized at a stage show
____ Have been hypnotized one on one
____ Have listened to hypnosis tapes or CD's
____ Have read books on hypnosis
____ Have friends/family who have been hypnotized

What are your beliefs about hypnosis?
____ I think it can help me
____ I will try it and see what happens
____ I am a skeptic

**FOR OFFICE USE ONLY:**

TCH CCH:

_____

Date: _____

Goals: _____

_____

_____

What are your three biggest personal strengths?
1.)
2.)
3.)

HEALTH: List all medical and mental health conditions for which you are currently being treated.

1.)
Diagnosis:_____

Treating Physician:_____
Medications:_____

2.)
Diagnosis:_____
Treating Physician:_____
Medications:_____

3.)
Diagnosis:_____
Treating Physician:_____
Medications:_____

4.)
Diagnosis:_____
Treating Physician:_____
Medications:_____

List any other health concerns, fears, or issues: _____
_____
_____

List any other medications: _____
_____

How much do you currently weigh? _____

What is your target weight? _____

Do you drink alcohol?
____ Never
____ Once a month
____ Once a week
____ A few times a week
____ Daily

Do you smoke cigarettes?
____ Never have
____ Former smoker - If so, when did you quit: _____
____ Yes, I am a light smoker - If so, How many cigarettes per day: _____
____ Yes, I am a heavy smoker - If so, How many cigarettes per day: _____

Your age when you started smoking?
_____

Do you use marijuana?
____ NO ____ YES - If so, How often: _____

Do you ____frequently _____occasionally use other drugs?
____ Cocaine or other stimulants
____ Ecstasy or club drugs
____ Heroin or Methadone
____ Unprescribed pain pills
____ Prescription pain pills
____ Prescription anti-anxiety medications (such as Valium or Xanax)
____ Unprescribed anti-anxiety medications
____ Other drugs - Specify: _____

Do you have sleep difficulties?
____ Rarely
____ I don't get enough sleep
____ I have trouble falling asleep
____ I have trouble staying asleep
____ I sleep too much

Eating Patterns:
____ I am on a special diet - Specify: _____
____ I eat mostly healthy foods
____ I don't eat regularly
____ I overeat
____ I do not eat enough
____ I binge eat
____ I purge myself when full
____ I snack too often

Exercise Patterns:
____ I work out frequently - Specify: _____
____ I exercise occasionally - Specify:_____
____ I do not get enough exercise
____ I have a health condition that limits my ability to exercise - Specify:_____
_____

In my personal relationships, I am:
____ Unsatisfied
____ Sometimes satisfied
____ Mostly satisfied
____ I am very happy with my relationships with others

What do you do to handle tension and stress? _____
_____
_____

What do you do for fun? _____
_____
_____

What are your hobbies? _____
_____
_____

What do you want to accomplish with hypnosis? _____
_____
_____