inTranceTherapy
TRANCEFORM YOUR LIFE

# CLIENT INTAKE FORM

## PERSONAL INFORMATION

Full Name

Date of Birth

Preferred Contact Number

Email

Address

Emergency Contact Name

Emergency Contact Number

Are you working?

☐ Yes ☐ No

What kind of work do you do?

Hobbies

## HISTORY

1. Are you currently taking medication?

☐ Yes ☐ No

If yes, what is it and why was it prescribed?

2. Are you currently under the care of a Medical Practitioner and/or Therapist?

☐ Yes ☐ No

If yes, please state the nature of the care they provide to you:

3. Have you ever been diagnosed with a mental illness?

☐ Yes ☐ No

If yes, please describe:

4. Has anybody in your family ever been diagnosed with a mental illness?

☐ Yes ☐ No

If yes, please describe:

5. Have you ever had Hypnotherapy before?

☐ Yes ☐ No

If yes, please describe your experience and outcome with Hypnosis:

6. What are you expecting we can help you with? Please tick, more than one answer possible.

- ☐ Anxiety
- ☐ Social Anxiety
- ☐ Performance Anxiety
- ☐ Stress
- ☐ Procrastination/ Motivation
- ☐ Mild Depression
- ☐ Phobia
- ☐ Trauma/PTSD
- ☐ Cessation of
  - ☐ Drinking
  - ☐ Binge eating
  - ☐ Smoking
- ☐ OCD
- ☐ Chronic Pain
- ☐ Other, please describe below:

7. Do you smoke?

☐ Yes ☐ No

If yes, how many cigarettes do you smoke in a day:

8. Describe your alcohol consumption?

- ☐ I don't drink at all
- ☐ Socially
- ☐ Occasional binges
- ☐ A glass or two at night
- ☐ I use it to help me sleep
- ☐ More than 10 drinks a week

9. Describe your sleep

- ☐ Good
- ☐ Variable
- ☐ Average
- ☐ Poor

If you have issues with sleep please describe them below:

10. Have you ever suffered from any of the following:

- ☐ Depression
- ☐ Anxiety
- ☐ Social Anxiety
- ☐ Phobias
- ☐ Chronic Insomnia
- ☐ Anger Management
- ☐ Eating Disorders
- ☐ Addictions
- ☐ Compulsive Disorders
- ☐ Chronic Pain
- ☐ Bipolar Disorders
- ☐ Schizophrenia
- ☐ Personality Disorder
- ☐ Other diagnosed
- ☐ None of the above

If other, please provide details:

11. Do you suffer from any of the following:

- ☐ Respiratory Problems
- ☐ Dizziness/Faintness
- ☐ Digestive Issues
- ☐ Back or Neck Pain
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Psoriasis/Skin Conditions
- ☐ None of the above

If you suffer from other conditions you believe I should know about, please describe below:

12. How is your general physical health?

- ☐ Good
- ☐ Average
- ☐ Poor

13. How is your mental health?

- ☐ Good
- ☐ Average
- ☐ Poor

14. How is your emotional health?

- ☐ Good
- ☐ Average
- ☐ Poor

Please list, if any, your allergies:

## MEDICAL DISCLOSURE

The therapy we provide at inTrance Therapy does not replace or is in any way a substitute for proper medical care from a qualified health care practitioner.

Please accept this disclosure to proceed with treatment:

☐ Yes, I accept Clinical Hypnotherapy & Strategic Psychotherapy is not a substitute for proper medical care.

I have pursued all reasonable medical avenues to deal with the presenting issue, and have been informed by my medical practitioner that it is not a physical but a psychosomatic issue:

☐ I agree ☐ Not applicable ☐ I disagree because:

I also recognise that inTrance Therapy will use Hypnosis as part of the treatment plan, and that I am seeking alternative/non-medical treatment that may not be supported or endorsed by some established medical practice.

☐ I agree ☐ I disagree

I understand that it is my responsibility to make any medical practitioner/therapist, that I am currently under the care of, aware that I am undertaking this alternative/non-medical treatment.

☐ I agree ☐ I disagree

Health fund rebates vary between funds and levels of cover. Additionally, changes in policy with regards to your cover can occur at any time. We cannot tell you if your particular health fund/health insurance policy will cover your Clinical Hypnotherapy/Strategic Psychotherapy Sessions.

☐ Yes, I accept that I will need to do my own research into my health funds coverage.

## CONFIDENTIALITY

Everything you say in clinic will be kept confidential. The circumstances only change if subpoenaed by the Court or the Client poses a risk to themselves or discloses a risk to others or omission of intent to commit or committing a serious crime.

☐ Yes, I understand that my information is kept confidential except the circumstances mentioned above.

Clinical Notes are kept by inTrance Therapy for a period of 7 years. They will only be released by request of the client or subpoenaed by the Court. Records are kept electronically as password encrypted files or physically in a locked filing cabinet.

☐ Yes I am aware of the Record Keeping Requirements

At inTrance Therapy the use of online technology such as Zoom Online Video Calls pose a risk to confidentiality. All though the risk is low if using online platforms to conduct online sessions you are agreeing to the risk.

☐ Yes, I agree the risk associated with confidentiality and Zoom

☐ No, I disagree

## CLIENT DECLARATION

I acknowledge that unless I give 24 hours' notice of a session cancellation I may be charged in full.

☐ Yes, I understand I need to give 24 hours' notice not to incur fees

I have read and understood the information provided to me in this document and understand that any sessions with inTrance Therapy will be designed and structured on the information supplied in this intake form.

☐ Yes, I understand

**Please contact InTrance Therapy with any questions if you DO NOT feel comfortable signing the consent form before you proceed.**

As a Mandatory Reporter inTrance Therapy is obliged by law to report to the authorities if we have reasonable concern for the safety of client or others as well as being informed with an omission of an intent to commit a serious crime.

☐ Yes, I understand the requirements of inTrance Therapy as a Mandatory Reporter.

In Hypnosis you will be in control and completely aware of your surroundings and what you take on board. The style is a modern of Ericksonian hypnosis that gives options instead of traditional directive hypnosis.

I consent to Hypnosis:

☐ YES

☐ NO

**Your signature at the end of this form indicates that you have read this document, that you have provided true and factual information therein and agree to the terms for all therapies provided by inTrance Therapy and its qualified therapist.**

## HOW DID YOU FIND OUT ABOUT INTRANCE THERAPY?

☐ Word of Mouth
☐ Google
☐ Doctor's Referral
☐ Other Therapist
☐ Instagram
☐ Facebook
☐ LinkedIn
☐ Other
☐ If other please describe:

Would you like to keep in contact with inTrance Therapy to be kept informed of workshops, events, information updates that would support and reinforce the work you do in your session here at InTrance Therapy.

☐ Yes ☐ No

## ANYTHING ADDITIONAL YOU WOULD LIKE TO ADD:

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Signature / Today's date

By law, if you are under 16 years consent from your parent or legal guardian is required and if you are 16-18yrs informed consent is required. Please tick below if you are under 18 years and InTrance Therapy will send you the appropriate consent form.

☐ Yes, I am under 18 years, please send me the consent form.

Please make sure to complete your **inTrance Therapy client intake form** 72 hours before your session and send it to: **Stephanie@inTrance.com.au**. It will ensure that you get the most out of your session time.

**Thank you!**