

VRishi Immersive Hypnotherapy

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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)

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:

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:

No Effect/Stress

Little Effect/Stress

Some Effect/Stress

Much Effect/Stress

Significant Effect/Stress

Doesn't Apply

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):

Client Homework:

My Homework:

Other Important Information:

Client/Parent Signature

Date