Carrie Swain
PROFESSIONAL CLINICAL HYPNOTHERAPY

(Therapist Use Only) Client Ref: ……..

GENERAL

CLIENT INTAKE AND CONSENT FORM

Part 1

CONFIDENTIAL

This intake form is to be completed by all new clients. All information you provide in this form will become part of your confidential records and will be handled in accordance with our Privacy Policy.

First Name(s) _____ Surname _____

Date of Birth _____

Address _____

_____

_____ Postcode _____

Tel No. (home) _____ Tel No. (work) _____ Ext. _____

Mobile No. _____ Email _____

GP Tel No. _____ GP Name _____

I hereby give my consent for you, Carrie Swain, to collect and process my above information, as required by you, the therapist, for the pursuance of both my own and your legitimate interests. I have read, understood and accept your **Privacy Policy** in respect of the handling of my recorded data.

Client signature _____ Date _____

Part 2

CONFIDENTIAL

Please circle the appropriate answer. If required, please include additional details to any of the questions below on a separate sheet, indicating the relevant question number.

1. Have you had any previous treatment for psychological issues? Yes No
   If yes, please give details – i.e. when, where, how long, provider name, medications, etc.

2. Are you currently taking (or have taken in the recent past) any prescription or over-the-counter medications? Yes No
   If yes, please give details.

3. Do you have any blood relatives who suffer with any psychological problems? Yes No
   If yes, please give details.

4. Do you smoke? Yes No
   If yes, please give details – how many, how often.

5. Do you drink alcohol? Yes No
   If yes, please give details – how much, how often, any blackouts, etc.

6. Do you use any recreational drugs? Yes No
   If yes, please give details – what drugs, how often, last use, etc.

7. Have you ever suffered from any type of eating disorder? Yes No
   If yes, please give details.

8. Do you have any work/school-related or relationship problems? Yes No
   If yes, please give details.

9. Do you have a history of trauma (any kind of abuse, neglect, victim of natural or other disaster, etc.)? Yes No
   If yes, please give details.

Part 3

CONFIDENTIAL

If required, please include additional details to any of the questions below on a separate sheet, indicating the relevant question number.

1. When does this symptom affect you most?

2. Where did it first happen and what did you do to overcome it?

3. What are the worst symptoms and how long do they last?

4. Why do you think it happens?

5. When do you not have it?

6. If I could click my fingers and you were instantly better or even instantly cured, then how would you feel and how would life be different?

Part 4

CONFIDENTIAL

Please circle as appropriate:

Sleep:	No problems	Not enough	Trouble getting up	Nightmares	Too much sleep
Appetite:	No problems	No interest	Increased appetite	Carbohydrate craving	
Energy:	Normal	Increased	Low	Up and down	
Interest in sex:	Normal	Increased	Low		
Concentration:	Normal	Somewhat difficult	Poor	Terrible	
Memory:	Good	Some difficulty remembering	Poor		
Anger/Irritation:	All the time	Most days	Some days	Not at all	
Anxiety:	All the time	Most days	Some days	Not at all	
Panic attacks:	Frequently	Occasionally	Not at all		
Depressed or sad:	All the time	Most days	Some days	Not at all	
Suicidal thoughts:	All the time	Most days	Some days	Not at all	
Past suicide attempts:	No	Yes ***(If yes, please give details below)***			

Any other Comments:

_____

_____

_____

_____

_____

_____

_____

(Continue on a separate sheet if necessary)

I hereby give my permission for you, Carrie Swain, to collect and process the above information, including any sensitive personal information as defined under the General Data Protection Regulations (GDPR) and as required by you, the therapist, for the pursuance of both my own and your legitimate interests. I have read, understood and accept your **Privacy Policy** in respect of the handling of my recorded data.

Client signature _____ Date _____

(Therapist Use Only)

Client Ref: ……..

NOTES