

Hypnosis Help Center

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Hypnotherapy Intake Questionnaire

Please fill out the following form, giving the first thought that comes to mind for each question. All information is kept strictly confidential.

Bruce Eimer, Ph.D.

Today's Date: _____

Name: _____ Date of Birth: _____

Sex: M F

Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____

Daytime Phone: (____) _____ Evening Phone: (____) _____

E-mail: _____

Marital Status: _____ Name of Spouse: _____

Names & Ages of Children: _____

1. List three of your favorite colors: _____

2. Name three of your favorite places: _____

3. List any fears or issues: _____

4. Do you suffer any compulsive tendencies? _____

5. List any current health issues: _____

6. List the medications you are taking: _____

7. List three of your most important lifetime goals: _____

8. List three of your pastimes or hobbies: _____

9. What is your current occupation? _____

10. Do you enjoy your current work? _____

11. List things that you like to do but would like to do better: _____

12. If you could what would you wish for, become or do? _____

13. Why are you seeking hypnosis? _____

14. How did you find this office? _____

15. Are you currently suffering from any of the following

- | | | |
|--|---|--|
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Cigarette smoking | <input type="checkbox"/> Marital problems |
| <input type="checkbox"/> Inability to relax | <input type="checkbox"/> Alcohol abuse | <input type="checkbox"/> Recent divorce |
| <input type="checkbox"/> Sleeplessness | <input type="checkbox"/> Drug abuse | <input type="checkbox"/> War trauma |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Compulsive overeating | <input type="checkbox"/> Current illness |
| <input type="checkbox"/> Sexual dysfunction | <input type="checkbox"/> Serious eating disorder | <input type="checkbox"/> Teeth grinding |
| <input type="checkbox"/> Compulsive tendencies | <input type="checkbox"/> Codependency | <input type="checkbox"/> Lack of energy |
| <input type="checkbox"/> Nail biting | <input type="checkbox"/> Inability to focus attention | <input type="checkbox"/> Death of a loved one |
| <input type="checkbox"/> Nightmares | <input type="checkbox"/> Abusive home situation | <input type="checkbox"/> Death of a pet |
| <input type="checkbox"/> Childhood trauma | <input type="checkbox"/> Abusive work issue | <input type="checkbox"/> Lack of success |
| <input type="checkbox"/> Fear of heights | <input type="checkbox"/> Sexual abuse | <input type="checkbox"/> Any other important issue |
| <input type="checkbox"/> Poor self-esteem | <input type="checkbox"/> Poor memory | |
| <input type="checkbox"/> Poor health | | |

16. One thing I feel guilty about is: _____

17. I am happiest when: _____

18. If I were not afraid to be myself I would: _____

19. I get so angry when: _____

20. I am most saddened by: _____

21. All of my life I: _____

22. Ever since I was a child I _____

23. One of the ways I could help myself but I don't is: _____

24. It is hard for me to admit: _____

25. I am a person who: _____

26. A mother should: _____

27. A father should: _____

28. A true friend should: _____

29. Mention your most significant memory, experience, or event that corresponds to each of these following periods of time in your life:

0-5 years old: _____

6-10: _____

11-15: _____

16-20: _____

21-25: _____

26-30: _____

31-35: _____

36-40: _____

41-45: _____

46-50: _____

51-55: _____

56-60: _____

61-65: _____

66-70: _____

70-100: _____

30. What behaviors get in the way of your happiness? _____

31. What would you like to start doing? _____
32. What would you like to stop doing? _____
33. What would you like to do more of? _____
34. What would you like to do less of? _____
35. What makes you laugh? _____
36. What makes you cry? _____
37. What makes you happy? _____
38. What makes you sad? _____
39. What makes you mad? _____
40. What makes you frightened? _____
41. What do you see or imagine yourself as doing in the next 6 months? _____

42. What do you **see or imagine** you are doing 5 years from now? _____

43. What **would you like** to be doing 5 years from now? _____

44. What would have to change or be different for that to happen? _____

45. What are your main beliefs and values? _____

46. What are the things you feel you should, can, and must do? _____

47. What motivates you? _____

48. In one word describe your life: _____
49. In one word describe your problems: _____
50. In one word describe the good times in your life: _____
51. One of the things I feel proud of is: _____
52. Do you observe any religious or meditative practice? If so describe: _____
- _____
53. Do you believe in past lives? _____
54. Please explain any other negative conditions affecting you: _____
- _____
55. Please list any additional needs or concerns: _____
- _____

Stress Level Profile

Instructions: Read each statement below and enter the number to the right of it that best represents you and your behavior at this time.

- 1 - not at all
- 2 - slightly
- 3 - moderately
- 4 - very much

1. I often lose my appetite or eat when I am not hungry _____
2. My decisions seem to be more impulsive than planned, I tend to feel unsure about my choices & often change my mind _____
3. The muscles of my neck, back and stomach frequently get tense _____
4. I have thoughts & feelings about my problems that run through my mind for much of the time _____
5. I have a hard time getting to sleep, wake up often or feel tired _____
6. I feel the urge to cry or get away from my problems _____
7. I tend to let anger build up & then explosively release my temper in some aggressive way or destructive way _____

8. I have nervous habits (tapping my fingers, shaking my leg, pulling my hair, scratching, wringing my hands, etc.) _____
9. I often feel fatigued, even when I have not been doing physical work _____
10. I have regular problems with constipation, diarrhea, or upset stomach _____
11. I tend not to meet my expectations either because they are unrealistic or I have taken on more than I can handle _____
12. I periodically lose my interest in sex _____
13. My anger gets aroused easily _____
14. I often have bad unhappy dreams or nightmares _____
15. I tend to spend a great deal of time worrying about things _____
16. My use of alcohol, coffee, cigarettes, and/or drugs has increased _____
17. I feel anxious, often without any reason that I can identify _____
18. In conversation my speech tends to be weak, rapid, broken, or tense _____
19. I tend to be short tempered and irritable with people _____
20. Delays, even ordinary ones, make me fiercely impatient _____

Challenges Checklist

Using a scale of 1-5 (with 1 being the most important and 5 being the least important), place the appropriate number on the lines below. Leave blank the issues that don't apply to you.

- | | |
|--|--|
| <p>__ Need a job</p> <p>__ Worn out by job</p> <p>__ Cannot save money</p> <p style="padding-left: 40px;">__ Long-term</p> <p style="padding-left: 40px;">__ Short-term</p> <p>__ Cannot get ahead</p> <p>__ Problems with co-workers or boss</p> <p>__ Dislike job or __ School</p> <p>__ Too much time to spare</p> <p>__ Bad habits</p> <p style="padding-left: 40px;">Describe _____</p> <p>__ Drug problems</p> <p style="padding-left: 40px;">Substance(s) _____</p> | <p>__ Drink too much</p> <p style="padding-left: 40px;">What and how much? _____</p> <p>__ Weight problems</p> <p style="padding-left: 40px;">Weight _____ Height _____</p> <p style="padding-left: 40px;">Desired weight _____</p> <p>__ Eat too much</p> <p style="padding-left: 40px;">What? _____</p> <p>__ Not enough exercise</p> <p style="padding-left: 40px;">Minutes/week _____</p> <p>__ Dissatisfied with appearance</p> |
|--|--|

Why? _____

__ Want to quit smoking

Cigarettes/day _____

__ Difficulty falling asleep

__ Cannot stay asleep

__ Poor memory

__ Studying is dull

__ Read too slowly

__ Poor concentration

__ Fears/issues

Of what? _____

__ Afraid of people

__ Low self esteem

__ Think about suicide

When?

__ Fear of dying?

__ Too emotional

__ Too nervous

__ Guilty feelings

__ Negative reaction to stress

__ Difficulty relaxing

__ Bad dreams

__ Feel awkward

__ Dislikes people

__ Cannot express emotions

Specify _____

__ Frequently cry

__ Different than others

Describe _____

__ Fear responsibility

__ Anger Quickly

__ Too critical of others

__ Violent/verbally abusive when angry

__ Do not trust others

__ Too sensitive

__ Feel sad frequently

__ Do not communicate

__ Speech problems

__ Fear of public speaking

__ Lack skills

__ Poor vision

__ Wear glasses

__ Procrastinate a lot

At work__ With personal stuff__

__ Poor organization

__ Would like to raise income

Presently:\$___/yr Desired:\$___/y

How soon? _____

__ Desire a promotion

__ Want to change career__ or job__

__ Work too dull

__ Afraid to take risks

Personal__ Business__

Blame others

Want to know my life mission

Need more goals

Lack of motivation__ ambition__

Trouble making decisions

Lack of education

Lack imagination

No time to relax

Desire more fun

Unwanted emotions
Specify_____

Wanted emotions absent
Specify_____

Depression: Frequency_____

Too Pessimistic

Legal Problems

Desire to see well without glasses

Hearing impairment

Cannot get up in the morning

Get sick a lot

Fear of poor health

Fear of mental health worsening

Aging faster then I prefer

Desire rejuvenation/slowing done of aging

Lack of energy

Blood pressure too High__ or too Low__

Menopause difficulties

Allergies
Types/symptoms_____

Physical pain

Spiritual problems

Difficulty meeting people
For Business__ or Personal__

Still grieving
Specify_____

Feel lonely

Too shy

Want a love relationship

Desire more sex

Unhappy marriage

Divorce
Contemplating__ going through__ are__

Relationship __breakup or __breaking up

Trouble with children

Trouble with a loved one

Quarreling at home

Difficulty making friends

Am not assertive
With business_____ or personally_____

List any other Challenges _____

In this space: Use your imagination...Express your concerns, issues, and/or dreams in the form of a drawing.

RELEASE STATEMENT

I hereby authorize Dr. Bruce Eimer to hypnotize me for the purposes outlined in this intake form and for the future purposes that I may request. I understand that the success of my hypnosis therapy depends greatly on my own ability and desire to effect change in myself. I understand that the results of my sessions depend greatly on my own serious participation, and that Dr. Bruce Eimer cannot offer any guarantee of the success of my treatment. I am aware, however, that Dr. Bruce Eimer will do everything in his power to ensure my success. I also understand that I have other choices from which to seek assistance regarding my specific concerns, and I have chosen hypnotherapy at this time.

Signature: _____ Date: _____

I understand that during the hypnotherapy session, Dr. Bruce Eimer may touch me as an anchoring technique. I hereby give my permission for such touch to take place during my session.

Signature: _____ Date: _____