Diana Paque Consulting

Services

Diana Paque, DPA, CCHt,

Certified Clinical Hypnotherapist, Reiki

Practitioner, Regressionist 707.319.1396

[www.sfbayregressions.com](http://www.sfbayregressions.com/) [www.dpconsulting.biz](http://www.dpconsulting.biz/) diana@dpconsulting.biz

Client Intake Questionnaire

Please fill in the information below and send it back in advance or bring it with you to your first session. Please note: information provided on this form is protected as confidential information.

**Personal Information**

|  |  |
| --- | --- |
| **Name** |  |
| **Parent/Legal Guardian (if under 18)** | L |
| **Address** |  |
| **Home phone Cell phone** |  |
| **Email** |  |
| **Where can we leave you a message?****(Home/cell/email)** |  |
| **Date of birth** |  |

|  |  |
| --- | --- |
| **Age** |  |
| **Marital status (Never married, Partnered, Married,****Divorced, Separated, Widowed)** |  |
| **Referred by (If any)** |  |
| **Are you currently employed? Yes/No** |  |

**General and Mental Health Information**

|  |  |
| --- | --- |
| **Have you previously received any type of medical health services? (psychotherapy, psychiatric services, etc)** |  |
| **If yes, name of previous therapist/ practitioner** |  |
| **Are you currently taking any prescription medications?****If yes, please list** |  |
| **Have you ever been prescribed psychiatric medication? If yes, what were you prescribed and when did you take it?** |  |
| **What is your history with hypnosis, hypnotherapy or guided imagery work?** |  |
| **What is your experience with psychedelic (plan medicine therapies/journeys?** |  |
| **How would you rate your current physical health? (Please choose one) Poor/Unsatisfactory/Satisfactory/Good/ Very good** |  |
| **Please list any specific health problems you are currently experiencing.** |  |
| **How would you rate your current sleeping habits? (Please choose one) Poor/Unsatisfactory/Satisfactory/Good/ Very good** |  |

|  |  |
| --- | --- |
| **How many times per week do you generally exercise? What types of exercise do you participate in?** |  |
| **Please list any difficulties you experience with your appetite or eating problems.** |  |
| **Are you currently experiencing overwhelming sadness/grief/or depression? If so, for approximately how long?** |  |
| **Are you currently experiencing anxiety, panic attacks, or have any phobias? Yes/No****If yes, when did you begin experiencing this?** |  |
| **Are you currently experiencing chronic pain?****Yes/No****If yes, please describe.** |  |
| **Do you drink alcohol more than once per week?** |  |
| **Do you engage in recreational drug use? Yes/No****If yes, How often?** |  |
| **Are you currently in a romantic relationship? Yes/No****If yes, for how long?****On a scale of 1-10 (1=poor and 10-exceptional), how would you rate your relationship?** |  |
| **Have you experienced any significant life changes or****stressful events recently? Yes/No****If yes, please describe.** |  |
| **Have you ever contemplated or attempted suicide?****Yes/No** |  |
| **Do you consider yourself spiritual or religious? Yes/No. If yes, describe your faith or belief.** |  |

 **Family History**

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member’s relationship to you in the space provided (e.g. father, grandmother, uncle, etc.)

|  |  |  |
| --- | --- | --- |
| **Issue** | **Yes/No** | **List Family Member(s)** |
| **Alcohol/ Substance Abuse** |  |  |
| **Anxiety** |  |  |
| **Depression** |  |  |
| **Domestic Violence** |  |  |
| **Eating Disorder** |  |  |
| **Obesity** |  |  |
| **Obsessive/Compulsive Behavior** |  |  |
| **Schizophrenia** |  |  |
| **Suicide Attempt(s)** |  |  |
| **Additional information about your family that is relevant to your treatment?** |  |
| **Do you have siblings?****Describe your relationship with them.** |  |
| **Is there additional information about your childhood that is relevant?** |  |

**Additional Information**

**Expectations -** We will review these in advance of the beginning of the session for additions and understanding.

|  |  |
| --- | --- |
| **What would you like to accomplish in therapy? In these sessions?** |  |
| **In preparation for your session, what specific questions do you want to ask or have answered?** |  |
| **I am aware that a recording will be made of my session and that I will be given a copy. Yes/No/Your initials** |  |
| **I give permission for recordings of my session to be used for research purposes and that any personal information will be withheld from research materials that are created and/or distributed.****Yes/No/Your initials** |  |
| **Signature and date** |  |