PARTNERS FOR HEALING AND CHANGEWORK
520 STOKES RD SUITE C-4
MEDFORD, NJ 08055
(609)-714-0222

INTAKE EVALUATION

NAME________________________________ DATE______________

ADDRESS_____________________________ D.O.B.____________

_____________________________ PHONE______________

WORK_______________________ CELL_________________

MAY WE CONTACT YOU AT WORK? YES NO (circle one) Yes/No

PLEASE WRITE WHAT THE REASON IS FOR SEEKING COUNSELING/HYPNOSIS AT THIS TIME?

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ARE YOU CURRENTLY UNDER A DOCTOR'S CARE?___________

PLEASE LIST ANY MEDICATIONS CURRENTLY AND THE TREATING PHYSICIAN'S NAME.

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DO YOU CURRENTLY USE ALCOHOL DRUGS (circle one)

IF SO, PLEASE LIST FREQUENCY AND AMOUNT AND SUBSTANCE OF CHOICE:

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HAVE YOU EVER ATTENDED COUNSELING/HYPNOSIS BEFORE?___________
If yes, please list your previous clinician, dates of service, and describe your experience.

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HAVE YOU EVER ATTEMPTED SUICIDE?__________
If yes, please indicate whether hospitalization was necessary and give dates.

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HAVE YOU EVER EXPERIENCED A TRAUMA? (i.e. physical abuse, sexual abuse or assault,death, bad accident, great loss, etc…) Yes No

WHAT IS IT THAT YOU WANT TO ACHIEVE OR CHANGE THROUGH COUNSELING/HYPNONIS?

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IS THERE ANY FAMILY HISTORY OF DRUG OR ALCOHOL ABUSE, PSYCHIATRIC ILLNESS, DEPRESSION, ANXIETY, SEXUAL ABUSE OR PHYSICAL ABUSE OR ASSAULT? IF SO PLEASE LIST WHO, WHICH ISSUE LISTED, AND WHETHER OR NOT TREATMENT WAS RECEIVED.

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By my signature below, I confirm that the information above is true and correct. I also verify that I understand and have been informed that Partners For Healing and Changework are not equipped with a 24 hour on call emergency system at this time. In the event of an emergency, I may call my local community mental health center or go to the nearest emergency room. If I feel this is a major treatment issue, I agree to inform the staff of Partners For Healing and Changework at this time.

Signature ____**Date** ______________________

Witness ____**Date** _____________________