Adult Intake Form

Praktijk Tranceforma | www.tranceforma.nl

Personal Information	
First name: Middle initials:	Last name: M/F
Address:	Postal Code/City:
Email:	Date of birth: Age:
Home phone:	Mobile:
Occupation: School/Study:	Work: no ☐ yes ☐ hours: Sick leave: no ☐ yes ☐ Employer:

Presenting Problem	
What is your complaint?	
What do you think is the cause of your complaint?	Since when have you had this complaint?
When do you have no/less trouble?	When do you have more trouble?
What is the desired goal of the therapy?	

Current Family Situation	
Single ☐ Married ☐ Divorced ☐ Living together ☐ LAT ☐ Widow/Widower ☐	
Do you have children? no ☐ yes ☐ Are your children from your current partner? no ☐ yes ☐	
1) ..... years contact? no ☐ yes ☐ 3) ..... years contact? no ☐ yes ☐	
2) ..... years contact? no ☐ yes ☐ 4) ..... years contact? no ☐ yes ☐	
Partner's name: ..... age	Does your partner work? no ☐ yes ☐ Occupation:
Family Situation in Childhood	
Is your father still alive? Yes, age: No, deceased in: Cause:	Is your mother still alive? Yes, age: No, deceased in: Cause:
How is/was your relationship with your father?	How is/was your relationship with your mother?
Do you have siblings? no ☐ yes ☐	
1) ..... age contact? no ☐ yes ☐ 3) ..... age contact? no ☐ yes ☐	
2) ..... age contact? no ☐ yes ☐ 4) ..... age contact? no ☐ yes ☐	
How would you describe your childhood? What was your role as a child in the family?	
Have you experienced trauma('s)? no ☐ yes ☐ Explanation:	

Health		
Drugs : no ☐ yes ☐ What:	How often/amount:	p.w.
Alcohol: no ☐ yes ☐ What:	How often/amount:	p.w./glasses

Do you have any of the following conditions?

☐ Heart problems	☐ High/Low blood pressure
☐ Epilepsy	☐ Diabetes
☐ Sadness/Depression	☐ Psychoses/Delusions
☐ Anxiety/Panic attacks/Hyperventilation	☐ Other:
☐ Hearing problems	

Do you use medication? no ☐ yes ☐ Which:

General Practitioner	**Specialist** ***(if applicable)***
Name:	Name:
Address:	Address:
Postal Code/City:	Postal Code/City:
Phone:	Phone:
Are you referred by GP? no ☐ yes ☐	Are you referred? no ☐ yes ☐
Contact with GP support Staff? no ☐ yes ☐	Currently or last 3 years under treatment? no ☐ yes ☐
With:	

How did you find me?			
☐ Internet	☐ Referral	☐ Recommendation	☐ Other:

Do you have experience with hypnotherapy? no ☐ yes ☐	Do you have experience with EMDR? no ☐ yes ☐

Anything else you find important to report or explain?	
Name:	**Signature*:**
Date:	

* I agree with the treatment method of Praktijk Tranceforma. I declare that I have filled in the above questions truthfully and am aware that providing incorrect or incomplete information may affect the outcome of the therapy.

YOUR PRIVACY (General Data Protection Regulation – GDPR)

For proper treatment, it is necessary that I, as your treating therapist, keep a client file. This is also a legal obligation under the Medical Treatment Contracts Act (WGBO). Your file contains notes about your state of health and information about the examinations and treatments carried out. The file may also contain information that is necessary for your treatment and that I have requested from another healthcare provider (for example your GP), but only after your explicit consent.

Your privacy is guaranteed. This means, among other things:

• careful handling of your personal and medical data
• ensuring that unauthorized persons do not have access to your data

As your treating therapist, I am the only person who has access to the information in your file. I am legally bound by professional confidentiality (duty of confidentiality).

The information in your file may also be used for the following purposes:

• to inform other healthcare providers, for example when therapy has been completed or when referring you to another practitioner — this will only be done with your explicit consent
• for substitution during my absence
• for anonymized use during peer review or professional consultation
• a small part of your file is used for financial administration, so that I or my administrator can prepare an invoice

If I wish to use your data for any other purpose, I will first inform you and explicitly ask for your permission. In accordance with legal requirements under the Medical Treatment Contracts Act, your client file will be kept for 15 years.

PRIVACY ON THE INVOICE

The healthcare invoice you receive contains the information required by your health insurer so that you can submit it for reimbursement:

• your name, address, and place of residence
• your date of birth
• the date of treatment
• a brief description of the treatment and the cost of the consultation