Hypnotherapy Intake Form

Name: _____ Date: _____

Address: _____

Email: _____Cell Phone: _____

Occupation: _____

Date of Birth:_____ Age: _____☐M, ☐F; Marital Status: ☐S, ☐M, ☐D, ☐W; Children? _____

How did you hear about us?

_____

Referral Name & Contact:

_____

Wearing contact lens? ☐ Yes ☐ No During hypnosis your eyes will be closed for about 45 minutes. If your contacts will cause eye irritation, you may want to bring your lens holder and solution so you can remove them just before hypnosis.

Hearing problem? ☐ Yes ☐ No I can position you for optimal hearing or speak louder if needed. If you normally wear a hearing aid, please use it as you will have your eyes closed and will not be able to lip-read during a session.

PRIMARY GOALS:

☐ Smoking/Tobacco Cessation; ☐ Self-Control with Alcohol; ☐Anger; ☐Other _____

☐ Stress Management; ☐Sleep Improvement; ☐Motivation/Procrastination; ☐ Confidence; ☐ Relationships;

☐Weight Management; ☐Attitude/Outlook; ☐Fear/Apprehension: _____

☐Study Skills; ☐Self-Esteem/Self-Image; ☐Facilitate Wellness; ☐Change Habit(s):

_____

BRIEF MEDICAL HISTORY: Are you under the care of a physician for any ongoing condition or illness?

☐ No ☐Yes Dr. _____ For: _____

Please list any significant current or past health issues or hospitalizations:

_____

_____

Are you in any physical pain, either intermittent or constant?

_____

Have you been diagnosed with any of the following?

☐OCD (Obsessive-compulsive disorder); ☐Severe Clinical Depression; ☐Schizophrenia; ☐Bipolar or manic-depressive; ☐Seizure disorder; ☐Post-traumatic-stress syndrome; ☐ Parkinson's disease; ☐Alzheimer disease or dementia; ☐Brain injury; ☐Diabetes. Details:_____

_____

Are you under the care of a mental health professional? ☐ No ☐ Yes Name: _____

For: _____

Any previous experience with hypnosis? ☐ No ☐ Yes

When: _____Reason: _____

Group or Individual?_____ How did it go for you?_____

Any objection if I make a general reference to a higher power, creative force, or universal force in your session?
☐ No ☐ Yes

Please briefly share anything else that would be helpful to know about you, (i.e., recent life-changing events such as deaths, divorce, relationships, job changes, health issues, past trauma, accidents, etc.):

_____
_____
_____
_____
_____