Date_____ (For office use) File:_____

CLIENT INTAKE INFORMATION FORM

The information requested in this form will be kept confidential. The goal is to help your Hypnotherapist assist you in the best, most efficient and safest manner possible. Please fill out the form as completely as you can.

GENERAL INFORMATION

Complete Legal Name:_____

Complete Street Address:_____

City_____State_____ Zip_____

Phone numbers: Home_____Work_____Cell_____

Can I leave a confidential voice mail on any of these phones? Yes or no?_____

If so, which phone? _____

Email_____(note this is for scheduling purposes only and communication only as *you* desire)

Date of Birth_____Age_____ Male? ☐ Female? ☐

Guardian/parent (if under 18) _____

Referred by _____

Reason for visit _____

Reason for choosing Hypnotherapy _____

_____

Religious Preference: _____

MEDICAL

Required: Do you have epilepsy, Yes or No? _____.

Required: Do you have phobias, Yes or No? _____. If "Yes", please describe: _____

_____

Required: Do you have a diagnosed mental illness, Yes or No?_____If "Yes," please describe[1]:

_____

[1] *If you are working with a medical or mental health care provider and have been diagnosed with a medical or mental disorder, and are taking prescription drugs for the disorder, and you want to work with Hypnotherapy on a behavioral issue, you will need to bring us a prescription from your health care provider to have us work with you for behavioral modification hypnotherapy.*

Date_____ (For office use) File:_____

Name and phone number of your physician:_____

Are you suffering any physical illnesses or symptoms at this time? _____

_____

List major surgeries or illnesses in the last five years:_____

_____

List current medications:

_____

_____

_____

_____

_____

_____

EDUCATION:

Please tell us about your education: _____

_____

_____

FAMILY

Are you: Single, Never married? ☐ Engaged? ☐ Married? ☐ Separated? ☐
Cohabiting? ☐ Widowed? ☐ Single/Divorced? ☐

Other?_____

Name of Partner/Spouse? _____

Parents: _____

Siblings: _____

Children:_____

Date_____ (For office use) File:_____

PROBLEM DEFINITION and PSYCHOLOGICAL HISTORY

Presenting problem (What issue has brought you here? How long has this been a problem? What was happening in your life when it first occurred?

_____

_____

_____

What is the reason for seeking help now?

_____

_____

Childhood history as it relates to presenting issue?

_____

_____

_____

Prior experience with hypnotherapy?

_____

_____

_____

Goals (how would life be different if this problem were resolved)?

_____

_____

_____

Resources (Who supports you in your healing process, spiritual guide's inner/external)?

_____

_____

_____

Tell me about your family: names and ages of spouse, children. Are there any major family problems? What would you like to see different in your family? Have you had any family death/loss?

_____

_____

_____

Date_____ (For office use) File:_____

Is there anything else you think I should know?

_____

_____

_____

Please check all that apply:

- ☐ Anxiety
- ☐ Grief
- ☐ Depression
- ☐ Irrational Fears/Phobias
- ☐ Nervousness
- ☐ Anger
- ☐ Marital/Relationship Problems
- ☐ Sexual Problems
- ☐ Loss of work/job
- ☐ Self-Esteem
- ☐ Stress
- ☐ Substance Abuse
- ☐ Chronic Fear
- ☐ Suicidal Feelings
- ☐ Loss of hope
- ☐ Rage
- ☐ Relationship to Parents
- ☐ Relationship to Children
- ☐ Loss of meaning in life
- ☐ Conflicts at Work
- ☐ Other (Please Describe)

_____

_____

Have you or any member of your family received help for drug or alcohol dependency?

No? ____Yes?____ When?_____ Who? _____

Have you received psychotherapy or counseling in the past?

No? ____Yes?____ When? _____ Why? _____

Please check any of the following that apply:

- ☐ Have you ever made a suicide attempt in the past?
- ☐ Do you have thoughts of harming yourself or others?
- ☐ Are thoughts of harming yourself or others a frequent occurrence?
- ☐ Do you dwell on these thoughts and wonder if you can control them?

Date_____ (For office use) File:_____

☐ Have you sought professional help because of these thoughts or feelings?

Have you ever been:

☐ Sexually abused? By whom_____ When _____
☐ Physically abused? By whom_____ When _____
☐ Verbally abused? By whom_____ When _____
☐ Emotionally abused? By whom_____ When_____

PAYMENT METHOD

Party responsible for payment:_____

Are you paying by:

☐ Cash
☐ Check #_____

ACKNOWLEDGMENT

Please sign and date this document attesting that the information you have written on this form is accurate to the best of your knowledge.

_____ _____
Client's Signature Date

_____ _____
If Child is a minor, Parent or Guardian's Signature Date