Dr. A.V. Badalamenti
NYS Certified Hypnotherapist
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INTAKE FORM

Date: _____E-Mail:(*Print clearly*) _____Referred by_____

Name: _____ Birthday: _____Right - Left Handed

Address: _____Town_____State_____Zip_____

Phone # (Home) _____(Cell)_____Rt. or Left Handed

Marital Status: M S D W Children? Yes / No List Children_____

_____

Emergency Contact Name, Number & Relationship_____

Occupation_____ List all education_____

Describe your health (past and present) _____

Any medication and/or vitamins: _____

Current issue/s for your appointment: _____

_____

Any Psychotherapy, counseling, or alternative therapies you've received? Yes No
Please list if any with treatment dates:_____

Do you sleep well? Yes No (explain)_____

History of seizures if any: No Yes (describe) _____

Any other Fears / Phobias? No Yes (list) _____

Are you in any physical discomfort? No Yes (please describe)_____

Any stress in your life? No Yes (explain)_____

Any tragedy in your lifetime? No Yes (explain)_____
_____

If appropriate, may I consult your physician/therapist? Yes No

(Please provide name, address, phone of treating physician/therapist _____

_____

Have you been hypnotized before? No Yes (how long ago & number of times) _____
Describe session: _____

What have you heard about hypnotherapy or hypnosis?_____

Describe a peaceful place: (the beach, lake, park etc.) _____

Would you describe yourself as a spiritual person? No Yes _____

List your life's accomplishments:(no matter how insignificant you think)

What have you tried to resolve your issue if anything? _____

I understand that good and lasting results may require several hypnosis sessions, and that I may be required to practice self-hypnosis and/or listen to a reinforcement recording between sessions at home. I am responsible for actively cooperating with, and participating in my program. Dr. A.V. Badalamenti, Certified Hypnotherapist, shall not be held accountable for the results I attain. I understand that I may be referred elsewhere for proper treatment if and when necessary and that my program may be terminated if deemed appropriate. I have read and understand the client bill of rights and acknowledge that all information about me will be kept confidential.

Signature: _____ Date: _____

GUARDIAN SIGNATURE (IF UNDER 18 YEARS OF AGE) Date: _____

(Print)_____Signature: _____