



Adult Intake Form

Today's Date: _____

Name: _____ Sex: ____ M ____ F

Address: _____

Phone numbers: Home: _____ Cell: _____

Email address: _____

Better way to reach you? _____

Date of Birth: _____ Place of Birth: _____

Marital /Relationship Status: _____

Children (ages, if applicable): _____

Current occupation /Profession: _____

Education: _____

Type of Services Requested (Please check all that apply)

- ☐ Psychotherapy ☐ Hypnotherapy ☐ Coaching
☐ Not sure – would like to discuss during first session

PRESENTING CONCERNS

Please briefly describe the issues that led you to seek therapy. You may include any physical, psychological, or social/environmental stressors or symptoms that feel relevant.

What do you perceive the problem to be? _____

Why therapy now? What prompted you to seek help at this time: _____

Adult Intake Form, cont.

MENTAL HEALTH AND MEDICAL HISTORY

Have you ever received therapy, coaching, or hypnotherapy before? ☐ Yes ☐ No

If yes, please describe the approach and your experience: _____

Past psychiatric diagnosis (if any): _____

Have you ever been hospitalized for mental health reasons? ☐ Yes ☐ No

If yes, please explain: _____

Are you currently taking medications? ☐ Yes ☐ No

If yes, list name, dosage, and purpose (if known): _____

Relevant medical history (chronic illness, surgeries, neurological or hormonal conditions, accidents, etc.): _____

Have you ever been hospitalized for mental health concerns? ☐ Yes ☐ No

If yes, when and for what reason? _____

Have you ever received treatment for alcohol or substance use? ☐ Yes ☐ No

If yes, when and for what substances? _____

Have you ever had experiences where your mind played tricks on you (e.g., hearing or seeing things others do not)? ☐ Yes ☐ No

If yes, please explain briefly: _____

Adult Intake Form, cont.

Have you ever been hospitalized for mental health reasons? ☐ Yes ☐ No

If yes, please explain: _____

Have you ever thought of committing suicide? ☐ Yes ☐ No

If yes, when? _____

Have you ever attempted to commit suicide? ☐ Yes ☐ No

If yes, when? _____

Have you ever received treatment for alcohol and/or drug use? ☐ Yes ☐ No

If yes, please specify date(s) and type(s) of treatment: _____

History of physical abuse? _____, if yes, when? _____

History of sexual abuse? _____, if yes, when? _____

ENVIRONMENTAL & CONTEXTUAL FACTORS

Please check or briefly describe any factors currently affecting your well-being:

☐ Financial stress or job instability ☐ Academic or work pressure ☐ Relationship or family conflict

☐ Caregiving responsibilities ☐ Recent loss or grief ☐ Legal or immigration issues

☐ Changes in living situation ☐ Community or cultural stressors ☐ Exposure to violence or trauma

☐ Other (please specify): _____

Is there anything in your current environment you feel is helping or hindering your well-being?

TREATMENT HISTORY & PREFERENCES

What have you already tried to address your concerns?

Adult Intake Form, cont.

What helped or worked for you in the past?

What used to help but no longer does?

Have you worked with a therapist, coach, or hypnotherapist before? ☐ Yes ☐ No

If yes, what was helpful or unhelpful about that experience?

Are there specific therapeutic approaches you are drawn to—or wish to avoid?

What are you hoping for in this process or therapeutic relationship?

MULTIMODAL SELF-REFLECTION

Please respond briefly to the prompts that apply to you. This section helps us better understand how you're functioning across different aspects of your experience.

Behavior: Are there any habits, routines, or behaviors you are trying to change? _____

Emotions: What emotional patterns do you notice most often (e.g., sadness, anxiety, anger, numbness)?

Physical Sensations: Do you experience body tension, pain, or energetic shifts when stressed? _____

Have you noticed any significant changes in the following areas?

- Sleep: _____

- Appetite or weight: _____

- Energy levels: _____

Adult Intake Form, cont.

Mental Imagery: Do you have recurring dreams, images, or mental “pictures” that affect your state of mind? _____

Thought Patterns: Are there persistent thoughts or beliefs that you find limiting or distressing? _____

Relationships: What relationships (past or present) feel significant to your healing process? _____

Health/Substances: Do you use medications, supplements, alcohol, or other substances that affect your mood or functioning? _____

OPTIONAL – HYPNOTHERAPY-RELATED INFORMATION

(Complete only if interested in or referred for hypnotherapy)

Have you ever experienced guided hypnosis or hypnotherapy before? ☐ Yes ☐ No

If yes, what was the focus or result of that experience?

Are you open to deep relaxation or altered states of awareness as part of your healing process?

Are there any concerns or hesitations you have about using hypnotherapy?

What goals would you like to work on using hypnotherapy?

Adult Intake Form, cont.

FINAL REFLECTIONS

Is there anything else you would like to share or bring to my attention? _____

Do you have any questions for me? _____

Thank you for taking the time to complete this intake form. We will review your responses together during our initial session to ensure your priorities and goals are fully understood.