CLIENT INFORMATION INTAKE

Name	Name you preferred to be called:
Address	Phone: ❑ Preferred Number
Referred by (or where did you hear about us:	Cell: ❑ Preferred Number Which number may we leave messages on if needed?
Date of Birth: Age: Marital Status:	
Email:	

Have you ever been hypnotized before? ❑Yes ❑No

Briefly explain:

What are your primary goals for this session?

What are your goals for long term (if different than initial session)?

Current Medical/Psychological Care

Are you under a medical doctor's care? ❑Yes ❑No

Briefly explain:

Doctor's Name
Address:

May we have permission to contact your doctor ❑Yes ❑No (optional)

Are you under a psychologist, psychiatrist or counselor's care? ❑Yes ❑No

Briefly explain:

Psych/Counselor's Name:

Address:

May we have permission to contact? ❑Yes ❑No (optional) Is your psych/counselor aware of this appointment? ❑Yes ❑No

Are you under the care of natural health practitioners? ❑Yes ❑No If yes, may we contact? ❑Yes ❑No

Name

Address

Type of practitioner:

List any other types of complementary health modalities you've tried. (ie, Reiki, Tai Chi, etc)

Have you been diagnosed with any of the following?
❑ Seizure Disorder ❑ OCD ❑ Depression
❑Post Traumatic Stress Disorder ❑ Schizophrenia ❑ Bi-Polar Disorder ❑ Other _____

Habits: Alcohol Tobacco Coffee/tea
Coffee/tea Special Diet Drugs (non-med)
Other:

Are there specific aspects of your life that are particularly stressful? (job, posture, habits, diet, family, etc.)
Explain:

Are you currently taking any medications (including herbal)? If so, what.

Are you in general good health? ❑Yes ❑No

Last physical date

Are you presently in any physical discomfort? ❑Yes ❑No

Are you currently wearing contacts? Yes / No
Any concerns with keeping eyes open/closed for 30 mins or more?

If you have had any of the following, please circle:
Cramps or numbness Eye trouble Asthma TB
Panic / anxiety attacks Epilepsy Heart trouble Blood Disease
High Blood Pressure

Briefly explain any other pertinent info:

(Continue)

Consent

Any/all information within this intake form and within the intake interview is strictly confidential unless hypnotherapist feels bodily harm to self or others may be at risk.

Payment is required at or prior to session. I understand the services are designed to be a health adjunct within the sphere of habit cessation and/or stress management and are in no way to take the place of a medical or psychological care. There is no guarantee for any specific results. Session recordings carry no guarantee for results or quality and do not carry any separate monetary value. You as the client have the responsibility to share any concerns.
We have a 24-hour cancellation policy.

If client is a minor, I hereby consent treatment.

_____ Date: _____
Signature, (relationship if minor)

Consultation Questionnaire

Date
Client's Name First Last
Have you ever been hypnotized before? Y/N If yes, by whom and circumstances
How did you find my services?

History with Complementary or Alternative Therapies

Type	Never Tried	Currently Use	Not for me	Interested In
Massage				
Acupuncture				
Chinese Herbs				
Other Herbs				
Homeopathy				
Chiropractic				
Osteopathy				
Nutrition				
Mind-Body (hypnotherapy, Biofeedback, etc)				
Reiki				
Other Energy Therapies (polarity, healing touch, etc)				
Others: List				

List 2 of your favorite colors	
Name 2 of your favorite places	
Do you have a fear or dislike of: ❑ Nature, forests, parks	❑ Water, ocean, rivers or lakes
❑ Stairs, escalators or elevators to beach	❑ _____
Which environments are most relaxing for you?	❑ Nature, forests, parks, trails
❑ Sights and sounds of water	❑ Quiet, secluded places
❑ Favorite Vacation	❑ Sporting and recreational activities ❑ _____
List 3 of your most important lifetime goals	
List 2 or more of your favorite hobbies or pastimes	
Do you suffer from any compulsive tendencies? Y/N If yes, list:	
Are you currently suffering from any of the following:	

❑ Nervousness ❑ Inability to relax ❑ Sleep problems ❑ Nail biting ❑ Nightmares ❑ Fears (List)	❑ Poor self esteem ❑ Cigarette Smoker ❑ Alcohol Abuse ❑ Drug Abuse (list) ❑ Eating Compulsion ❑ Inability to Focus	❑ Poor Memory ❑ Past Abuse (Physical/Sexual/Verbal) ❑ Current Abuse (Physical/Sexual/Verbal) ❑ Recent Divorce/Split ❑ Current Illness (List)	❑ Teeth Grinding ❑ Lack of Energy ❑ Lack of Success ❑ Other (List)

Energy

Rate your overall energy level at various times of the day by circling the appropriate spot on the line below.

Morning

1 2 3 4 5 6 7 8 9 10

Low energy High energy

Afternoon

1 2 3 4 5 6 7 8 9 10

Low energy High energy

Evening

1 2 3 4 5 6 7 8 9 10

Low energy High energy

Sleep

How well do you sleep?
Do you wake up in the morning feeling rested? □ No □ Yes
Are you tired much of the time? □ No □ Yes
Has anyone mentioned that you have severe snoring? □ No □ Yes
What time do you usually go to bed? _____o'clock AM / PM
How long does it take for you to fall asleep? _____minutes/hours
How many hours a night do you sleep? ____hours
If you don't fall asleep easily, explain what happens: _____
_____
Do you wake up in the middle of the night? How often?
Do you nap during the day? □ No □ Yes
If yes, how often: _____ How long: _____minutes/hours
Do you feel rested after napping? □ No □ Yes
Has there been a recent change in your sleep pattern? □ No □ Yes If so, please describe:
Do you dream? □ No □ Yes Do you remember them? □ No □ Yes
Have you experienced any recurring or "important" dreams? □ No □ Yes Describe:

I feel happiest when:
I feel unhappiest when:
What would you like to start doing, if you could:
What makes you laugh?
What makes you cry?
What makes you mad?
What makes you sad?

Where do you see yourself and what do you imagine yourself doing 6 months from now?

… 5 years from now?
Do you know what motivates you the most?

Stress Level Profile

Read each statement and rate 0-10 0 = Not at all 10 = Constantly

I lose my appetite when stressed.
I over eat when stressed.
The muscles of my neck, back are in spasm.

I have stomach/bowel distress/pain.
I feel the urge or tendency to cry for no reason.
I tend to let anger build, then explode.
I have nervous habits (tapping, shaking leg, hair pulling, scratching, etc.)
I often feel fatigued, even when not being physical.
I spend a great deal of time worrying.
I feel anxious.
I tend to be short tempered and irritable with people.
Emotional
Guilt
Sensitive
Cannot easily rise in morning.

Preventive Health
Do you regularly exercise? ☐ No ☐ Yes Explain
Do you partake in any kind of meditation/mindfulness exercise? ☐ No ☐ Yes Explain
Are there specific things that you do in order to maintain your health? ☐ No ☐ Yes Explain
Are you currently on a special diet? ☐ No ☐ Yes If yes, describe
Do you belong to an organized religion? ☐ No ☐ Yes If yes, in what way?
What do you do to relax?
Where is your favorite place to relax?
What is your favorite season?
Do you have a personal spiritual practice? ☐ No ☐ Yes If yes, describe

Relaxation Methods				
Type	Never Tried	Currently Use	Not for me	Interested In
Watch TV				
Progressive Relaxation				
Meditation				
Visualization/Guided Imagery				
Hypnosis/Self-Hypno				
Yoga				
Tai Chi/Chi Gong				
Massage/Bodywork				
Biofeedback				
Others: List				