Adham Therapy LLC

New Client First Visit Intake Form

Supportive Wellness Services | Clinical Hypnotherapy | Life Coaching | Health & Wellness Coaching

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Purpose: This form helps Adham Therapy LLC understand your goals, background, safety considerations, and preferences before or during the first visit. It is intended for supportive wellness services and is not a medical or psychiatric intake.

1 Client / Patient Information

Full Name: _____	**Date:** _____
Date of Birth: _____	**Age:** _____
Phone: _____	**Email:** _____
Address: _____	**City / State / ZIP:** _____
Preferred Contact: ☐ Phone ☐ Text ☐ Email	**Best Time to Contact:** _____
Emergency Contact: _____	**Relationship / Phone:** _____

2 First Visit / Referral Information

Appointment Date / Time: _____	**Session Type:** ☐ In-person ☐ Virtual ☐ Phone
Referred By: ☐ Self ☐ Clinic ☐ Doctor ☐ Family/Friend ☐ Other	**Referring Provider / Clinic:** _____
Primary reason for visit: _____	**How did you hear about us?:** _____

3 Primary Concerns / Goals - Check All That Apply

☐ Stress regulation / relaxation support	☐ Habit change / behavior modification
☐ Smoking cessation support	☐ Sleep routine / relaxation support
☐ Motivation and wellness follow-through	☐ Confidence / self-image support
☐ Emotional self-regulation skills	☐ Lifestyle adherence / health behavior change
☐ Weight-management behavior support	☐ Mindset / limiting-belief work
☐ Focus / attention / follow-through	☐ Other: _____

4 Goals for First Visit / Relevant Notes

What would you like to feel, change, understand, or improve after working together?

_____

_____

_____

_____

5 Health Insurance / Payment Information

Client has health insurance: ☐ Yes ☐ No ☐ Unknown	**Self-pay inquiry:** ☐ Yes ☐ No ☐ Unknown
Insurance Company / Plan: _____	**Member ID / Policy #:** _____
Group #: _____	**Subscriber Name / DOB:** _____

Adham Therapy LLC - First Visit Form Continued

6 Medical / Mental Health Background

Currently under medical care?: ☐ Yes ☐ No ☐ Unknown	**Doctor / Clinic Name:** _____
Currently seeing therapist / psychiatrist?: ☐ Yes ☐ No	**Provider Name:** _____
Current medications or supplements?: ☐ Yes ☐ No	**If yes, list:** _____
Prior hypnotherapy / NLP / coaching?: ☐ Yes ☐ No	**What helped / did not help?:** _____
Known diagnosis / disorder?: ☐ Yes ☐ No ☐ Unknown	**If yes, specify:** _____

7 Safety / Scope Screening

☐ Any active safety concern or crisis risk?
☐ Current suicidal or homicidal thoughts?
☐ Active psychosis, hallucinations, delusions, or unmanaged mania?
☐ Schizophrenia or schizophrenia-spectrum diagnosis?
☐ Substance-use concern currently affecting stability?
☐ History of seizure, dissociation, or medical concern relevant to hypnosis?

Important: Adham Therapy LLC does not accept referrals or new-client work for schizophrenia or schizophrenia-spectrum / active psychotic disorder needs. Urgent psychiatric, medical, safety, or crisis needs should be directed to licensed providers, crisis services, emergency departments, or 911 as appropriate.

8 Attention / ADHD Information - If Applicable

ADHD diagnosis?: ☐ Yes ☐ No ☐ Suspected ☐ Unknown	**Diagnosed by:** _____
ADHD Type: ☐ Inattentive ☐ Hyperactive-Impulsive ☐ Combined ☐ Unspecified	**Medication / Prescriber:** _____
Attention / executive-function goal: _____	**Precautions / triggers:** _____

9 Preferred Support / Session Preferences

☐ Clinical hypnotherapy session	☐ Life coaching support	☐ Health & wellness coaching
☐ Stress / relaxation plan	☐ Habit-change support	☐ Smoking cessation support
☐ Behavior follow-through support	☐ Sleep routine support	☐ Other: _____

10 Scope of Practice, Consent & Signature

Scope: Adham Therapy LLC services are supportive wellness services and educational in nature. They do not diagnose, treat, cure, or manage medical or psychiatric conditions and do not replace medical care, psychotherapy, psychiatry, medication management, crisis care, or emergency services.

☐ I understand this form is for supportive wellness intake and is not medical or psychiatric treatment.	
☐ I understand additional consent, intake, or privacy forms may be required before services begin.	
☐ I authorize Adham Therapy LLC to contact me regarding scheduling and intake coordination.	
Client Signature: _____	**Date:** _____
Printed Name: _____	**Parent/Guardian if minor:** _____