HYPNOTHERAPY CLIENT INTAKE FORM

Disclaimer: Thank you for your interest in being a client of .
This form is used to collect information about new clients and is used for internal purposes only. The information you provide is confidential and will be treated accordingly.

PERSONAL INFORMATION

Client Name: _____ **Date of Birth**: _____

Street Address: _____

City: _____ **State**: _____ **ZIP Code**: _____

Phone: _____ **E-Mail**: _____

Occupation: _____ **Gender**: ☐ Male ☐ Female ☐ Other

Relationship Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other: _____

Emergency Contact: _____ **Phone**: _____

BACKGROUND INFORMATION

How did you hear about us? _____

Have you been hypnotized before? ☐ Yes ☐ No
If yes, describe your experience:

Describe the goals or outcomes you hope to achieve through hypnosis:

List any fears or phobias that you have:

Describe the places, real or imaginary, that relax you and put you at peace:

Are you spiritual or religious? ☐ Yes ☐ No

- If yes, what belief system? _____

Do you have children? ☐ Yes ☐ No

- If yes, how many? _____
- What are their ages? _____

Do you consume alcohol? ☐ Yes ☐ No

- If yes, how many drinks per week? _____

Do you smoke? ☐ Yes ☐ No

- If yes, what do you smoke? ☐ Tobacco ☐ Marijuana ☐ Other: _____
- How many cigarettes do you smoke per day? _____

How many hours of sleep do you get per night? _____

- What's the quality of your sleep? ☐ Good ☐ Average ☐ Poor ☐ Varies

Do you practice self-care (e.g., meditate, walk outdoors, journal)? ☐ Yes ☐ No

- If yes, explain: _____

Do you exercise regularly? ☐ Yes ☐ No

- If yes, how many days per week? _____

Do you wear contact lenses? ☐ Yes ☐ No

While in hypnosis, your eyes will be closed for around 45 minutes. If wearing contacts causes you eye irritation, it is advisable to have your lens holder and solution on hand so that you can safely remove them.

Do you have a hearing problem? ☐ Yes ☐ No

If you use a hearing aid, please wear it to ensure optimal hearing. Your eyes will be closed during our sessions and lip-reading won't be possible.

HEALTH

Have you been treated by a psychologist, psychiatrist, or therapist? ☐ Yes ☐ No

If yes, provide details regarding the duration of treatment, any diagnoses received, and the overall effectiveness:

Do you suffer from seizures or epilepsy? ☐ Yes ☐ No

Do you suffer from asthma? ☐ Yes ☐ No

Do you suffer from depression? ☐ Yes ☐ No

Do you or have you ever suffered from substance abuse? ☐ Yes ☐ No

- If yes, explain: _____

Do you suffer from chronic pain or migraines? ☐ Yes ☐ No

- If yes, explain: _____

Have you had a check-up within the past year? ☐ Yes ☐ No

Do you currently receive care from a physician for a physical condition, illness, or disease? ☐ Yes ☐ No

If yes, describe the care and provide the name and phone number of each professional

List any prescription medications you currently take:

LIFE ISSUES

Which of the following issues currently affect your life?

☐ Anxiety	☐ Lack of Focus	☐ Physical Health
☐ Depression	☐ Life Changes	☐ Racing Mind
☐ Fatigue	☐ Loss of Self	☐ Relationships/Family
☐ Fear of Death	☐ Mental Health	☐ Sadness
☐ Fear of Future	☐ OCD	☐ Sleep
☐ Finances	☐ Overwhelming Empathy	☐ Spirituality/Religion
☐ Grief/Loss	☐ Perfectionism	☐ Stress
☐ Inadequacy	☐ Phobias	☐ Work

Share any other issues, recent life-changing events, or any other information that would be helpful for us to know about:

SIGNATURE

Client Signature: _____ **Date**: _____

Print Name: _____