



Hypnotherapy Intake Form

Please answer the questions below and return this form to your therapist:

Client's name:
Date:
Address:
Contact Telephone Number:
Age:
Marital status:
No. of children:
Hobbies/interests:
Occupation:
Symptoms and Duration of Symptoms you would like to reduce or eliminate:
A favorite, relaxing place (ocean, lake, trees, beach...):
If you have a spiritual connection, please provide name or belief system (optional):

Fears and phobias (heights, closed spaces, water....) :

Compulsive habits:

Do you suffer from asthma or allergies?

Have you ever suffered from depression?

Have you suffered from epilepsy or seizures in the last two years?

Have you ever had treatment from a psychologist/psychiatrist/therapist? If so, list the duration, any diagnosis given, and if treatment has been helpful.

Have you been hypnotized before?

Where did you hear of this practice?

- Local Directory
- PCP/other doctor
- Friends/Family
- Other (Please state):

Current state of health:

Are you currently taking any drugs/medication:

**Are you currently receiving medical treatment or therapy for an illness, disease, or physical condition?
Please describe**

Do you suffer from migraines and/or chronic pain issues?

Please list the names of all physicians you are currently seeing:

Anything else you want to share with me:

Consent to hypnosis:

Signature:

Name (Printed):

Date: