Hypnotherapy Intake Form

Patient Information

Patient Name: _____ DOB: _____ Sex: _____

Home Phone: _____ Cell: _____

Address: _____

Medical History

Are you currently under a physician's care? ❑ Yes ❑ No Provider: _____

Do you currently see a therapist? ❑ Yes ❑ No Therapist: _____

Treatments: _____ Effective? _____

Current Medications: _____

Current Stressors: _____

How well do you sleep? _____ How many hours per night? _____

Do you get angry often? _____ What angers you most? _____

Do you worry often? _____ What worries you most? _____

Are you happy? _____ What makes you happiest? _____

Are you pregnant? ❑ Yes ❑ No Trying? ❑ Yes ❑ No Breastfeeding? ❑ Yes ❑ No

Do you have epilepsy? _____ High/low blood pressure? _____ Diabetes? _____

Exercise Activities: _____ Hours per week: _____

Hypnotherapy

Reason for Visit: _____

What do you expect from hypnotherapy? _____

Have you experienced hypnotherapy before? _____

If yes, what were the results? _____

How did you hear about us? _____

If referred, who referred you? _____

Questions:

Comments:

_____ _____

Patient Date