CAPISTRANO HYPNOTHERAPY

949-680-5286

CLIENT INTAKE FORM

Date: _____

Name: _____ Date of Birth: _____ Age: _____

Address: _____City: _____ Zip: _____

Email: _____ Pref. Mode of Contact: Ph ___ Txt ___ Email ____

Phone: Home _____ Work _____ Mobile _____

Occupation: _____ Referred by: _____

Emergency Contact: _____ Ph: _____ Relationship: _____

Marital Status: _____ Spouse's Name, if applicable: _____

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Primary Doctor: _____ Phone: _____

Present Medications: _____ List on reverse if necessary.

List any current health problems: _____

Have you ever been diagnosed with any of the following?: Epilepsy__Depression__Schizophrenia__

Bi-Polar Disorder__Psychosis__Multiple Personality Disorder__Others_____

If yes, when? _____ By whom? _____

Any other known significant mental health issues? _____

Do you: Smoke Cigarettes _____ Use Recreational Drugs _____ Drink Alcohol _____

Anything else you feel is important? _____

Why are you seeking Hypnotherapy? _____

What goals or changes would you like to achieve? _____

_____

Describe any physical symptoms you are experiencing if applicable_____

_____

How long has it affected your life? _____

What other therapies have you tried? _____

Client Intake

Describe how your life will be different with your issue resolved. Be very specific. How will you feel about yourself, what will be different in your life?_____

_____

_____

_____

_____

_____

Are you currently suffering from: (Select all that apply)

☐ nervousness ☐ inability to relax ☐ sleeplessness ☐ sexual dysfunction ☐ nail biting ☐ compulsive tendencies ☐ nightmares ☐ poor health ☐ cigarette smoking ☐ alcohol abuse ☐ drug abuse ☐ compulsive overeating ☐ serious eating disorder ☐ codependency ☐ inability to focus attention ☐ poor memory ☐ marital problems ☐ recent divorce ☐ war trauma ☐ current illness ☐ teeth grinding ☐ lack of energy ☐ death of a loved one ☐ childhood trauma ☐ poor self-esteem ☐ abusive home situation ☐ abusive work situation ☐ abusive relations of any source ☐ lack of success ☐ sexual abuse ☐ pain disorder ☐ infertility ☐ pregnancy issues ☐ phobias/fears

What are the specific outcomes you would like to achieve from hypnosis? _____

_____

_____

_____

Print Name:_____

Signature:_____Date:_____

Doctor's Name:_____ Phone#_____

Doctor's Name:_____ Phone#_____

Doctor's Name:_____ Phone#_____

(required for medical issues only)