# HYPNOTHERAPY CLIENT INTAKE FORM

Disclaimer: Thank you for your interest in being a client of Sheri Galvanized. 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**:

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**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? _____
- If yes, does the activity increase your heart rate? _____

**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? Please circle or check.**

| | | |
|---|---|---|
| ☐ 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: _____