Hypnosis Intake Form

Patient: _____ Date: _____

Email: _____ Phone: _____

Address: _____

Employer: _____ Phone: _____

Position: _____ Length of Time: _____

Previous Hypnosis: ❑ Yes ❑ No Date(s): _____

Purpose: _____

Results: _____

Marriage Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed No. of Children: _____

Contact Lenses? ❑ Yes ❑ No Hearing Condition(s): _____

Diagnoses: ❑ Bipolar Disorder ❑ Schizophrenia ❑ Epilepsy ❑ PTSD ❑ Depression ❑ OCD

Current Medications: _____

Hypnosis Target

❑ Smoking	❑ Alcohol	❑ Drugs
❑ Nail-Biting	❑ Weight Loss	❑ Memory Loss
❑ Relationships	❑ Pregnancy/Childbirth	❑ Marriage/Divorce
❑ Sleep	❑ Stress	❑ Anger
❑ Anxiety/Fear	❑ Motivation	❑ Studying
❑ Pain	❑ Medical Issue	❑ Mental Health
❑	❑	❑

Notes/Comments: _____