

PRIVATE AND CONFIDENTIAL

Client 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:
Duration of symptoms:
Previous treatment for this problem:
Fears and phobias:

Compulsive habits:
Do you suffer from asthma or allergies?
Have you ever suffered from depression?
Have you suffered from epilepsy in the last two years?
Have you ever had treatment from a psychologist/psychiatrist/therapist ?
If yes please provide details:
Have you been hypnotized before?
Where did you hear of this practice?
<input type="checkbox"/> Local Directory <input type="checkbox"/> GP <input type="checkbox"/> Radio <input type="checkbox"/> Friends/Family <input type="checkbox"/> T.V. <input type="checkbox"/> Other (Please state):
Current state of health:
Are you currently taking any drugs/medication:
Details of any major operations:
Doctor's name and address:

Consent to hypnosis:

Signature:

Name (Printed):

Date: