Starfish Hypnosis
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HYPNOTHERAPY INTAKE FORM

Date: _____

CLIENT INFORMATION

Full Name: _____

Date of Birth: _____ Age: _____

Address: _____

City: _____ State: _____ Zip:

_____ Phone: _____

Email: _____

Occupation: _____

EMERGENCY CONTACT

Name: _____

Phone: _____

Relationship: _____

HEALTH HISTORY

Do you have any medical conditions? ❑ Yes ❑ No

- If yes, please specify: _____

Medical conditions… cont

Are you currently under medical or psychological care? ❑ Yes ❑ No

- If yes, please specify: _____

Are you taking any medications? ❑ Yes ❑ No

- If yes, please list: _____

Do you have a history of mental health conditions (e.g., anxiety, depression, PTSD, schizophrenia, etc.)? ❑ Yes ❑ No

- If yes, please specify: _____

Have you ever been hypnotized before? ❑ Yes ❑ No

- If yes, what was your experience like? _____

Do you have any history of seizures, epilepsy, or dissociative disorders? ❑ Yes ❑ No

Do you have any phobias or fears related to hypnosis or loss of control? ❑ Yes ❑ No

Are there any limiting beliefs, behaviors, or habits you want to change?

How long have you been experiencing this issue?

On a scale of 1 to 10, how much does this issue affect your daily life?

(1 = Not much, 10 = Extremely) _____

Have you tried other methods (therapy, coaching, meditation, etc.) to resolve this issue? ❑ Yes ❑ No

- If yes, what worked or didn't work? _____

LIFESTYLE & SLEEP HABITS

How many hours of sleep do you get on average? _____

Do you have a history of sleep disorders (insomnia, nightmares, etc.)? ❑ Yes ❑ No

Do you consume caffeine or alcohol? ❑ Yes ❑ No

Do you engage in regular exercise or relaxation techniques (yoga, meditation, etc.)? ❑ Yes ❑ No

Family and childhood history:

PERSONAL DATA

Date of Birth

Height

Weight

_____

_____

_____

Check any of the following that applied during childhood: _____ Night Terrors Bedwetting _____, Sleepwalking _____, Thumb sucking _____,Nail Biting _____, Fears _____, Stammering ____, Happy Childhood _____,Unhappy Childhood___, Other(s)

_____

_____

_____

Did you like school? _____

How well did you do?

_____

History of learning problems? _____

Explain:

_____ _____

Health during childhood? _____

List Illnesses

_____

Health during adolescence? _____

List Illnesses

_____

List any surgical operations and age at the time

_____

_____

Any accidents?

_____

List your five main fears:

1._____

2._____

3._____

4._____

5._____

Check any of the following that apply to you:

Headaches _____, Dizziness _____, Fainting Spells _____, Suicidal Ideas _____, Anger _____, Fatigue _____, Bowel Disturbances _____, Dislike Vacations _____, Palpitations _____, Anxiety _____, Unable to Relax _____, Nightmares _____, Bad Home conditions _____, No appetite _____, Can't make Friends _____, Inferiority Feelings _____, Feel Tense _____,Financial Problems _____, Compulsive Eating _____, Depressed _____, Alcoholism _____, Lonely_____, Excessive Sweating _____, Unable to have a good time _____, Tremors _____, Stomach Trouble _____, Often use aspirin _____,Over ambitious _____, Take Drug _____,Take Sedatives _____, Can't make decisions _____, Allergies _____, Memory problems _____, Repeating Thoughts _____, Feel Sick _____, Concentration difficult _____, Don't Like Weekends _____, Shy _____,

Have you ever felt like hurting yourself?

_____

When and how?

_____

_____

Have you ever thought about hurting someone else?

_____

Explain_____

_____ _____

Check any of the following words which apply to you:

Worthless _____ , Useless _____ , Inadequate _____ , Stupid _____ ,
Morally Wrong _____ , Ugly _____ , Can't Do Anything Right _____ ,
Unassertive _____ Depressed _____, A 'nobody' _____, Incompetent _____,
Hostile _____, Agitated _____, "Life is Empty" _____, Naive _____,
Guilty _____, Full of Hate _____ , Cowardly _____ , Misunderstood _____, Lonely
_____ , Aggressive _____ , Confused _____, Horrible Thoughts____, Full of
Regret _____, Sympathetic _____, Intelligent _____, Unattractive _____,
Worthwhile _____, Attractive _____, In Conflict _____, Considerate _____,
Confident _____,Evil _____, Anxious _____, Unloved _____,

Other:

_____

_____

_____

Present interests, hobbies, and activities_____

_____

_____

How is most of your free time occupied?

_____

_____

Were you ever bullied or severely teased? If yes, when and how?

_____

_____

Have you ever been arrested or convicted of a criminal offense? _____ If yes, describe the nature, time_____

_____

Were you ever in the Military? _____ Date(s) of service_____ Type of Discharge_____

_____

Any other Information not mentioned:

HYPNOTHERAPY CONSENT & RELEASE FORM

I_____, acknowledge that:

- Hypnosis is a **collaborative process** and I am responsible for my own progress.
- Hypnotherapy is **not a replacement** for medical or psychological treatment.
- The hypnotherapist is **not a licensed medical doctor or psychologist** and does not diagnose or prescribe.
- I understand that hypnosis is **a natural and safe method** for self-improvement.
- Results vary from person to person, and **no guarantees** can be made.
- I agree to be open and willing to participate in the process.

❑ **I consent to receive hypnotherapy and understand the above statements.**

Client Signature: _____

Date: _____

Hypnotherapist Signature: _____

Date: _____

Confidentiality

All personal, medical, and psychological information provided in this form will be kept strictly confidential in accordance with relevant privacy laws and ethical standards. The information you provide will only be shared with other professionals or entities if required by law or with your explicit consent.