# *Tahoe Hypnotherapy*

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## INTAKE FORM

Name: _____
(Last) (First) (Middle Initial)

Name of Parent/guardian (If under 18 years of age)

_____
(Last) (First) (Middle Initial)

Birthdate: _____ / _____ / _____ Age: _____ Gender: _____

Marital Status

[ ] Never Married [ ] Domestic Partnership [ ] Married [ ] Seperated

[ ] Divorced [ ] Widowed

Please list any children/age _____

Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone: (_____) _____ May we leave a message? Y / N

Cell/Other Phone: (_____) _____ May we leave a message? Y / N

E-Mail: _____
May we email you? [ ] Yes [ ] No
Please note Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): _____

Have you previously received any type of mental health ervices (psychotherapy, psychiatric services, etc.)?
[ ] No

[ ] Yes, previous therapist/practitioner : _____

Do you enjoy your work? Is there anything stressful about your current work?

_____

_____

Do you consider yourself to be spiritual or religious? Yes [ ] No [ ]

If yes, describe your faith or belief:

_____

What do you consider to be some of your strengths?

_____

_____

_____

_____

What do you consider to be some of your weakness?

_____

_____

_____

_____

What would you like to accomplish out of your time in hypnosis?

_____

_____

_____

_____

Are you currently experiencing anxiety, panic attacks or have any Phobias?

[ ] No [ ] Yes

If yes, please describe: _____

Do you drink alcohol more then once a week? [ ] No [ ] Yes

How often do you engage in recreational drug use?

[ ] Daily [ ] Weekly [ ] Monthly [ ] Infrequently [ ] Never

Are you currently in a romantic relationship? [ ] No [ ] Yes

If yes, for how long? _____

On a scale of 1 – 10, how would you rate your relationship? _____

What significant life changes or stressful events have you experienced recently:

_____

**FAMILY MENTAL HEALTH HISTORY:**

In this section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided, (father, grandmother, uncle, etc.)

| History of: | Please Circle | List Family Member |
|---|---|---|
| Alcohol/Substance Abuse | Yes No | |
| Anxiety | Yes No | |
| Depression | Yes No | |
| Domestic Violence | Yes No | |
| Eating Disorders | Yes No | |
| Obesity | Yes No | |
| Obsessive Compulsive Behavior | Yes No | |
| Schizophrenia | Yes No | |
| Suicide Attempts | Yes No | |

**ADDITIONAL INFORMATION;**

Are you currently employed? [ ] Yes [ ] No

If yes, what is your current employment situation: _____

_____

Are you currently taking any prescription medication? [ ] Yes [ ] No

Please list: _____

_____

Have you ever been prescribed psychiatric medication? [ ] Yes [ ] No

Please list: _____

_____

**GENERAL HEALTH AND MENTAL HEALTH INFORMATION**

How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific health problems you are currently experiencing:

_____

How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific sleep problems you are currently experiencing:

_____

How many times per week do you generally exercise? _____

What types of exercise do you participate in: _____

Please list any difficulties you experience with your appetite or eating problems:

_____

Are you currently experiencing overwhelming sadness, grief, or depression?

[ ] Yes [ ] No

If yes, for approximately how long? _____