

General Intake Questionnaire

Name _____

Date _____

Before your session, it is important that you respond to the following items. Please print legibly or type!

1. Address _____ e-mail _____

2. City, Zip, _____ Phone _____ Age _____

3. How did you hear about us? _____

4. A favorite relaxing place that is safe _____

5. Indicate if you are afraid of: heights, water, closed spaces, other _____

6. Educational level _____ Occupation _____

7. Medications you are taking _____

8. Are you receiving treatment for a disease or condition that produces chronic pain or discomfort? Please explain.

9. Household: (Circle all that apply) Married, Single, Partner, Children (# & Ages) _____ Other _____

9. Have you ever been in psychotherapy? If so, please explain when, with whom, for how long, and for what purpose.

10. Do you meditate? Y / N

11. Have you been formally hypnotized? Y / N If yes please describe. _____

Issue Background

12. The main reason or goal for your session is:

13. What benefits would you gain from solving this problem?

14. What would success look, sound and feel like?

15. What habits or patterns might contribute to the problem?

16. Please list three important concerns regarding this issue for you.

17. Are there any secondary gains that might be happening from having or holding on to this problem?

18. Family / close friends support or hindrance on this issue?

19. Is there any other information you can provide that that you feel would be beneficial for the practitioner to be aware of?

Check (✓) the items you may want to address in future sessions.

Stress / Anxiety	Anger	Fears	Divorce
Smoking	Life Purpose	Confidence	Trauma
Weight	Remove Blocks	Creativity	Surgery Prep.
Alcohol / Drug	Memory	Communications	Fear Flying / Travel
Improve Concentration	Self-esteem	Financial / Abundance	Dating / Romance
Motivation	Testing / Academic	Healing Imagery	Letting Go / Releasing
Regressions / Progressions	Sleep	Career / Work	Grief
Spiritual Connection	Sports Improvement	Health Issues	Cancer
Relaxation	Pain Management	Healing Imagery	Dental Visits
Sleep	Self-Sabotage	Arthritis	Other

Please return this intake form 24 hrs. prior to your appt. Thank You!

Notes _____
