



Sacramento Hypnotherapy

*Behavioral Therapy
and Clinical Hypnotherapy*

CONFIDENTIAL CLIENT INFORMATION AND HEALTH HISTORY

First Name: _____ M.I. _____ Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone (h): _____ (c): _____ Birth Date: ____ / ____ / ____

Email Address: _____ Marital Status: _____

Male Female Referred by: _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

How much water do you drink in a day? _____ Do you consider yourself stressed? _____

Have you ever used the services of hypnotherapy? ____ If yes, by whom? _____

Have you ever used the services of psychotherapy? ____ If yes, by whom? _____

Please list any medication (vitamins, herbs or pharmaceutical) taken now or at regular intervals. Include an explanation of what the medication is used to treat: _____

Please list any conditions that currently affect you, or that you have experienced within the last 2 years.

MUSCULOSKELETAL SYSTEM

- Fibromyalgia
- TMJ
- Pain
- Other _____

RESPIRATORY SYSTEM

- Asthma
- Trouble Breathing
- Dizziness
- Other _____

CIRCULATORY SYSTEM

- Anemia
- Hypertension
- Heart Condition
- Other _____

DIGESTIVE SYSTEM

- Ulcers
- Irritable Bowel Syndrome
- Indigestion
- Other _____

NERVOUS SYSTEM

- Spinal Cord Injury
- Seizure Disorders
- Numbness/Tingling/Twitching
- Other _____

OTHER CONDITIONS

- Insomnia
- Anxiety/Panic Attacks
- Frequent Headaches
- Other _____

All of the information provided in this intake form is accurate and true to the best of my knowledge. I understand that Hypnotherapists do not diagnose disease or prescribe medications. I further understand that hypnotherapy is not a substitute for medical attention and examination. I take full responsibility for alerting my practitioner to any physical, mental or emotional changes that occur with my health.

Signature _____ Date: _____

