Body Mind Healing Journey

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Client Intake Form

Please take a moment to fill out this form with any information you believe will be helpful in your session. Thank you.

Name _____Date _____

Address _____ Apt _____

City _____ State _____ Zip Code _____

Email Address _____

Is it okay to use this email to confirm appointments or send audio files? _____

Phone number (preferred) (_____)_____

Is it okay to leave phone messages for you at this number? _____ Texts?_____

What is your main focus for your consultation?

What are your goals just for today?

What are your goals for the long term?

What is your main motivation?

When have you had past success, with this or a similar type of issue?

Who is on your team? Please give names of friends, family, pets, etc. who are significant to your process right now:

Do you have a spiritual belief system? A spiritual practice, such as meditation or prayer? Do you have a name for your spiritual connection?

How is your physical health? Diet & exercise? Sleep patterns?

What is your occupation/work background?

How is your stress level, on a scale of 1 to 10? What do you do to manage it?

What else would you like me to know?

Your Medical History

Name, address and phone number of your primary care provider

Where and when was your last physical? Was anything about this visit notable? If so, explain briefly:

When was your last lab or any other medical tests (such as an EKG) ? Please provide any details you know.

Allergies:

Adverse Drug Reactions:

Any chronic health conditions?

History of surgeries:

Any current (acute) illness?

Have you ever had any mental health treatment, such as with a counselor, therapist, or psychiatrist? _____

a. If yes, give a brief history of your mental health treatment and the results of your treatment:

b. Are you receiving any mental health treatment now?_____

c. If yes, name of mental health professional: _____

d. Have you spoken to your mental health professional about hypnotherapy as an adjunct to your treatment? _____

Do you have thoughts of hurting yourself, or taking your own life?

Do you have thoughts of hurting someone else or taking their life?

Check if you have, or have had, any symptoms in the following areas to a significant degree within the last year, and briefly explain.

☐ Visual Changes/Loss	☐ Shortness of breath	☐ Changes in muscle strength
☐ Head Injury	☐ Asthma or Emphysema	☐ Falling
☐ Headaches	☐ High blood pressure	☐ Hepatitis A, B or C
☐ Seizures	☐ Chest pain, heart attack	☐ Sexually Transmitted Infections
☐ Hearing Loss	☐ Constipation or Diarrhea	☐ Elevated cholesterol or glucose levels
☐ Nose	☐ Difficulty controlling bowel or bladder	☐ Diabetes
☐ Throat	☐ GYN problems	☐ Memory problems
☐ Thyroid disorder	☐ Cancer/Tumors/Cysts	☐ Difficulty with sleep
☐ Allergies	☐ Back Pain	☐ Childhood Illness - specify
☐ Recent Weight Changes	☐ Other pain:	☐ Other chronic health issues:

Comments:

Current Medication, herbs and supplements:

Name	Dose	Directions	Do you take daily	Do you take as needed medications (prns)

Are you currently pregnant, breast feeding or planning a pregnancy soon?

Recent Blood pressure (if known)_____