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Client Intake Form

The Client Intake Form helps me to obtain a brief medical history and understanding of your goals for hypnosis. All information is kept in strict confidence. I will not be able to perform any hypnosis sessions without this complete form.

Date:	Year of Birth:	
Name:		
Street Address:		
City:	State:	Zip Code:
Phone Number:	Email:	

How did you hear about New Beginning Hypnosis?

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Have you ever been hypnotized? ☐ Yes ☐ No

What is the main reason you are seeking hypnosis?

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Medical & Emotional History

Which of the following are you currently experiencing or have experienced in the last 90 days as it applies to your physical health? Please check all that apply.

☐ Allergies	☐ Diabetes	☐ Nail Biter	☐ Unexplained Pain
☐ Epilepsy	☐ IBS	☐ Smoker	☐ Flushing/Blushing
☐ Body Pain	☐ Headaches	☐ Low Energy	☐ Hearing Problems
☐ Body Aches	☐ Migraines	☐ Heart Problems	

Please list any additional thoughts you may have about your health:

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About Your Fears: *Please check all that apply.*

- [ ] Animals
- [ ] Snakes
- [ ] Spiders
- [ ] Stairs
- [ ] Intimacy
- [ ] Body Fluids
- [ ] Bridges
- [ ] Traffic
- [ ] Darkness
- [ ] Heights
- [ ] Needles
- [ ] Dentist
- [ ] Doctors
- [ ] Dogs
- [ ] Escalators
- [ ] Boats
- [ ] Flying
- [ ] Frogs
- [ ] Climbing
- [ ] Hate
- [ ] Surgery
- [ ] Driving
- [ ] Highways
- [ ] Illness
- [ ] Insects
- [ ] Birds
- [ ] Lightning
- [ ] Lizards
- [ ] Men
- [ ] Going Out
- [ ] Death
- [ ] Bugs
- [ ] Germs
- [ ] Avoid Cracks
- [ ] Being Alone
- [ ] Stinging Insects
- [ ] Driving
- [ ] Public Speaking
- [ ] Test Anxiety
- [ ] Women
- [ ] Not Pleasing Others
- [ ] Water/Swimming
- [ ] Sight of Blood
- [ ] Other / None of These

Please list any additional thoughts you may have about your fears:

About Your Mental Attitude: *Please check all that apply.*

- [ ] Abuse Alcohol
- [ ] Angry Thoughts
- [ ] Anxiety
- [ ] Being Alone
- [ ] Being Touched
- [ ] Chewing Mouth
- [ ] Closed in Spaces
- [ ] Depression
- [ ] Do/Did Drugs
- [ ] Poor Memory
- [ ] Feel Inadequate
- [ ] Hair Pulling
- [ ] Hair Twisting
- [ ] Hand Washing
- [ ] Hear Mumbling
- [ ] Hear Voices
- [ ] Highway Anger
- [ ] Skin Picking
- [ ] Insommia
- [ ] Missing Time
- [ ] Mood Swings
- [ ] Self Harm
- [ ] Nightmares
- [ ] P.T.S.D.
- [ ] Panic Attacks
- [ ] Past Abduction
- [ ] People too Close
- [ ] Embarrass Easily
- [ ] Impulsive Behavior
- [ ] Negative Thoughts
- [ ] Poor Concentration
- [ ] Rambling Thoughts
- [ ] Reoccurring Dreams
- [ ] Suicidal Thoughts
- [ ] Sleep Walker
- [ ] Other / None of These

Please list any additional thoughts you may have about your mental attitude:

About Your Desired Change

About The Changes You Desire: *Please check all that apply.*

☐	Spiritual Growth	☐	End Stage Fright	☐	Peace	☐	Control Alcohol Use
☐	Control Cancer	☐	Find Your Joy	☐	Personal Healing	☐	Control Drug Use
☐	Stop Smoking	☐	Healing	☐	Positive Thinking	☐	Enhance Learning
☐	Control IBS	☐	Improve Memory	☐	Rid Writers Block	☐	Improve Study Habits
☐	Control Pain	☐	Increase Energy	☐	Self Confidence	☐	Sports Enhancement
☐	Control Stress	☐	Increase Sales	☐	Self -Hypnosis	☐	Stop Nail Biting
☐	Creativity	☐	Lose Weight	☐	Sleep Better	☐	Other / None of These
☐	End Grief	☐	Stop Nail Biting	☐	Stop Test Anxiety	☐	

Please list any additional thoughts you may have about your desired changes:

Confidentiality and Client Acknowledgement

I understand and acknowledge that hypnosis is not and does not replace medical treatment. New Beginning Hypnosis practitioners are not medical doctors and as such, our practitioners do not diagnose conditions. Hypnosis and other modalities of healing work work well in conjunction with traditional medical treatments. New Beginning Hypnosis recommends seeking the advice of a medical doctor before beginning any type of treatment plan.

New Beginning Hypnosis does not record sessions and keeps client data in the strictest of confidence. We do not disclose any information regarding your session, except in cases where we are compelled through a court order or subpoena with which we are bound to comply.

If you wish for us to discuss any details of your treatment with a referring physician or other individual, we will require your explicit written consent in order to do so out of respect for your privacy.

Signature: ______________________ Date: ____________

Print Name: ______________________