CONFIDENTIAL CLIENT INTAKE FORM

Please answer all questions and print clearly. Thank you.

First Name: _____Last: _____M.I.: ____ Initial Appointment Date: _____

Address: _____Apt. #_____

City: _____ State: _____ZIP: _____ Email: _____

Phone Nos.: Primary (_____) _____ Secondary (_____) _____

Employer: _____Occupation: _____

Date of Birth: _____ Age: _____ ☐M ☐F Marital Status: ☐S ☐M ☐D ☐W Children? _____ How many? _____ Ages: _____

**Wearing contact lens?** _____ Your eyes may be closed for much of your appointment time.

**Hearing problem?** _____ I can position you for optimal hearing or speak louder if needed. If you normally wear a hearing aid, please use it as you will have your eyes closed and will not be able to lip-read during a session.

**MARKETING INFORMATION: Thank you for helping us promote our services. How did you hear about NoVA Hypnosis and Wellness?**

☐Yelp ☐Internet Search Engine: _____ ☐ Outdoor/Car Ad ☐ Online Ad ☐ Magazine Ad: _____

☐ Referral… His/Her name: _____May we send them a thank you note? _____

Mailing or Email Address if known: _____

►**Desired Services & Products:** ☐ Hypnosis ☐ Reiki ☐ EFT ☐ Health Coaching ☐ Guided Meditation Classes ☐ Yoga

►**PRIMARY GOALS:** ☐ Smoking/Tobacco Cessation ☐ Alcohol Cessation Support ☐ Weight Management ☐ Stress Management ☐ Pain Management: _____ ☐ Testing/Performance Anxiety: _____

☐ Fears: _____ ☐ Change Habit(s): _____ ☐ Cancer Treatment Support ☐ Performance Enhancement (e.g. improved golf swing):_____ ☐ Sleep ☐ Improved Attitude/Outlook ☐ Facilitate Wellness ☐Life Transition Assistance ☐ Alleviate Medical Condition (e.g. wart elimination, allergy relief): _____ ☐ Other: _____

**BRIEF MEDICAL HISTORY:**

Are you under the care of a mental health professional? _____ Name: _____

For: _____

Are you under the care of a physician for any ongoing condition or illness? _____ Dr. _____

For: _____

Have you had a check-up or physical within the past year? _____ Please list any significant current or past health issues or hospitalizations:

_____

_____

Are you in any physical pain, either intermittent or constant? _____

_____

Have you ever been diagnosed with any of the following? ☐ OCD ☐ Severe Clinical Depression ☐ Schizophrenia ☐ Bipolar/Manic-Depressive

☐ Seizure Disorder ☐ ADD/ADHD ☐ Post-Traumatic Stress Disorder ☐ Parkinson's ☐ Alzheimer or Dementia ☐ Brain injury ☐ Diabetes

☐ Hypertension ☐ High Cholesterol ☐ Thyroid or other Glandular disorder

Details:_____

Any previous experience with Hypnosis? _____ When: _____ Reason:_____

_____

Group or Individual?_____ How did it go for you? _____

Any previous experience with Reiki? _____ When: _____ Reason:_____

_____

Reiki may done <u>with</u> or <u>without</u> touch. What is your preference? _____

Please briefly share anything else that would be helpful to know about you, (e.g. recent events such as deaths, divorce, relationships, job changes, etc.):

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*"I certify that the information provided in this intake form is true and complete to the best of my knowledge."*

_____

Signature

_____

Printed Name

_____

Date Form Completed