

Just Relax Hypnosis Intake Form

Please complete the following forms and return via email to info@justrelaxhypnosis.com.

Name

First Name

Last Name

Phone Number

Phone Number

Email

example@example.com

Address

Street Address

Street Address Line 2

City

State / Province

Postal / Zip Code

Gender:

Marital Status:

Emergency Contact

Name

First Name

Last Name

Phone Number

Phone Number

How did you hear about Just Relax?

Personal Referral

Website

Online Search

Bark

Personal History

Please answer the following questions to the best of your ability. This information is confidential.

Have you ever been treated by a hypnotherapist?

Yes

No

What issues prompted you to seek hypnotherapy treatment?

When did the issue you are seeking hypnotherapy for begin?

How is this particular issue affecting your day-to-day life?

What led you to seek hypnotherapy now?

What other therapies have you used or tried to address this issue? Did you notice an improvement or changes with these therapies? If so, please briefly explain.

Briefly describe your goals for hypnotherapy. What do you hope to accomplish in working together?

Are you currently under a medical doctor's care for an issue related to your hypnotherapy goals?

- Yes
- No

If yes, please briefly describe how you are currently being treated for this issue.

Have you ever been diagnosed with a chronic illness? If so, please briefly describe.

Have you ever been diagnosed with a clinically recognized mental illness?

- Yes
- No

Are you currently under the care of a psychologist or psychiatrist?

- Yes
- No

Does Michael Longshore of Just Relax Hypnosis have your permission to contact your psychologist or psychiatrist?

- Yes
- No

If yes, please give the name and contact for your psychologist or psychiatrist:

Office Number

Please enter a valid phone number.

Have you ever experienced a seizure or been diagnosed with seizure disorder?

- Yes
- No

Are you currently on any medications? Please briefly describe.

Check any of the following symptoms you are currently experiencing or have experienced in the past year:

- Anxiety
- Panic Attacks
- Nervousness
- Headaches
- Unexpected Weight Loss
- Poor Sleep / Insomnia
- Sweats

- Depression
- Fears / Phobias
- Forgetfulness
- Migraines
- Unexpected Weight Gain
- Numbness or Tingling Sensations

- Poor Appetite
- Bowel Changes
- Diarrhea
- Excessive Thirst
- Heart Burn / Indigestion
- Stomach Pains or Cramps
- Blood in Stool

- Bloating
- Constipation
- Excessive Hunger
- Gas
- Nausea
- Vomiting

- Bleeding Gums
- Difficulty Swallowing
- Excessive Ear Wax
- Ringing in Ears
- Nosebleeds
- Sinus Issues
- Vision Changes

- Blurred Vision
- Ear Aches
- Loss of Hearing
- Hoarseness
- Persistent Coughing
- Environmental Allergies

- Pain, weakness or numbness in limbs
- Low Blood Pressure
- Irregular Heart Beat
- Rapid Heart Beat
- Hormone Imbalance
- Hair Loss
- Acne
- Warts
- Sores
- Lack of Bladder Control
- Painful Menstrual Cramps

- Chest Pains
- High Blood Pressure
- Poor Circulation
- Swelling of Ankles
- Low Libido
- Crying Spells
- Hives
- Rash
- Frequent Urination
- Painful Urination

Have you been diagnosed with any of the following conditions or undergone any of the following treatments?

- | | |
|------------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Acute Pain | <input type="checkbox"/> AIDS |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Anorexia |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Autoimmune Disease |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Bulimia |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Chemical Dependency |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Chronic Pain |
| <input type="checkbox"/> Crohns | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Dialysis | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Gastritis | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Irritable Bowel Syndrome |
| <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Miscarriage |
| <input type="checkbox"/> Post-Surgical Healing | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> PTSD | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Radiation Therapy | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Yeast Infections |
| <input type="checkbox"/> <input type="text"/> | |

Please write any other symptoms or conditions not listed:

If you have allergies, please list below.

Lifestyle Questions

Please answer the following questions to the best of your ability. This information is confidential.

What do you typically eat in a day?

How often do you drink coffee?

- Daily
- Occasionally
- Never

How often do you drink tea?

- Daily
- Occasionally
- Never

How often do you drink alcohol?

- Daily
- Occasionally
- Never

How often do you smoke cigarettes or vape?

- Daily
- Occasionally
- Never

How often do you use recreational drugs?

- Daily
- Occasionally
- Never

How often do you drink the recommend amount of water?

- Daily
- Occasionally
- Never

How often are you physically active for 30+ minutes?

- Daily
- Multiple days per week
- Occasionally
- Never

What physical activities do you enjoy?

Do you follow or align with the beliefs of a particular religion? If so, please briefly describe your spiritual beliefs or practices.

Is there anything else you want me to know before working together?

Consent & Acknowledgement

By signing below, I acknowledge and understand the services rendered by Just Relax Hypnosis and its employees are NOT intended to replace medical or psychological treatment or consultation. Hypnosis is effective with a large number of issues and areas, however, the provider does not under any circumstance diagnose, prescribe, treat or attempt to cure any physical, mental, or emotional disorders. Just Relax and its employees are here to facilitate and empower your self-healing using guided imagery. Individual results may vary. No cures, results or specific outcomes are guaranteed.

Signature:

Date:
