

# MARCIA PROCTOR HYPNOTHERAPY

*Marcia D. Proctor, CHT*

## CLIENT INTAKE FORM

NAME: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: HOME \_\_\_\_\_ MOBILE \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_ SEX: \_\_\_\_\_

EMAIL: \_\_\_\_\_ MARITAL STATUS: \_\_\_\_\_ CHILDREN: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

EMPLOYER'S ADDRESS: \_\_\_\_\_

HOW DID YOU HEAR ABOUT MARCIA PROCTOR HYPNOTHERAPY? (PLEASE CHECK ALL THAT APPLY)

MEDICAL REFERRAL:  PHYSICIAN  PSYCHOLOGIST  RELATIVE  FRIEND  INTERNET  COWORKER

OTHER: \_\_\_\_\_

HAVE YOU EVER BEEN HYPNOTIZED? YES  NO

IF SO, DESCRIBE WHEN, WHERE, WHY, BY WHOM \_\_\_\_\_

HAVE YOU EVER WALKED IN YOUR SLEEP? YES  NO

YES  NO

HAVE YOU EVER WALKED IN YOUR SLEEP? YES  NO

YES  NO

### MEDICAL HISTORY

HAVE YOU RECEIVED TREATMENT (PHYSICAL OR PSYCHOLOGICAL) IN THE PAST YEAR? IF YES, PLEASE DESCRIBE:

\_\_\_\_\_

NAME OF PHYSICIAN OR PSYCHOLOGIST \_\_\_\_\_ PHONE \_\_\_\_\_

HAVE YOU EVER BEEN TREATED FOR AN EMOTIONAL PROBLEM? \_\_ YES \_\_ NO

ARE YOU CURRENTLY RECEIVING TREATMENT OR COUNSELING? \_\_ YES \_\_ NO

HAVE YOU HAD ANY PROLONGED ILLNESS \_\_ YES \_\_ NO (IF YES, WHEN?) \_\_\_\_\_

HAVE YOU EVER BEEN TREATED FOR? (CHECK ALL THAT APPLY) \_\_ DIABETES \_\_ EPILEPSY \_\_ HEART CONDITION

IF YES, WHEN? \_\_\_\_\_

NATURE OF PRESENT PROBLEM? (REASON YOU ARE SEEKING HYPNOTHERAPY TREATMENT)

\_\_\_\_\_

ANY PREVIOUS EFFORTS TO SOLVE THE PROBLEM? \_\_ YES \_\_ NO

RESULTS? \_\_\_\_\_

ARE YOU CURRENTLY UNDERGOING MEDICAL OR PSYCHOLOGICAL TREATMENT FOR THE PROBLEM? \_\_ YES \_\_ NO

WHERE? \_\_\_\_\_

CLIENT SIGNATURE: \_\_\_\_\_

*Client acknowledges understanding this questionnaire and all information provided is complete and accurate to the best of their knowledge.*

*All information is strictly confidential.*