

Clinical Hypnotherapy | NLP | Coaching

Intake Form

Date: _____

Name: _____

Name you prefer we use: _____

Date of Birth: _____ Age: _____ Sex: F M

Address: _____

City: _____ State: _____ Zip: _____

Phone Number (____) _____ (____) _____ (____) _____
Home Cell Work

E-Mail Address: _____

Occupation: _____ SS#: _____

Healthcare Provider: _____

Do you visit your doctor regularly: _____ For what? _____

Please list all medical conditions you have _____

Please list all medications that you take _____

Drug Allergies: _____

How did you hear about me? Friend/Family(who) _____

Internet Yellow Pages Other: _____

Emergency Contact Name: _____ Phone: _____ Relationship: _____

By signing this form I give my consent to receive input at Synergy including NLP Coaching, Hypnotherapy, Trance Work, and Craniosacral. I understand this work is guided by a certified practitioner. I understand I may discontinue a session at any time. I realize that the treatment is given for the well-being of my mind and body. All information will be kept in strict confidence. My information may be shared among practitioners at Synergy. I have stated all medical conditions that I am aware of and will update the therapist(s) and practitioner(s) of any changes in my health status.

Signature: _____ Date: _____

Synergy Holistic Health Center

7309 US Hwy 42, Suite 1, Top Floor, Florence, KY 41042

(859) 525-5000 | www.synergyholistichealth.com

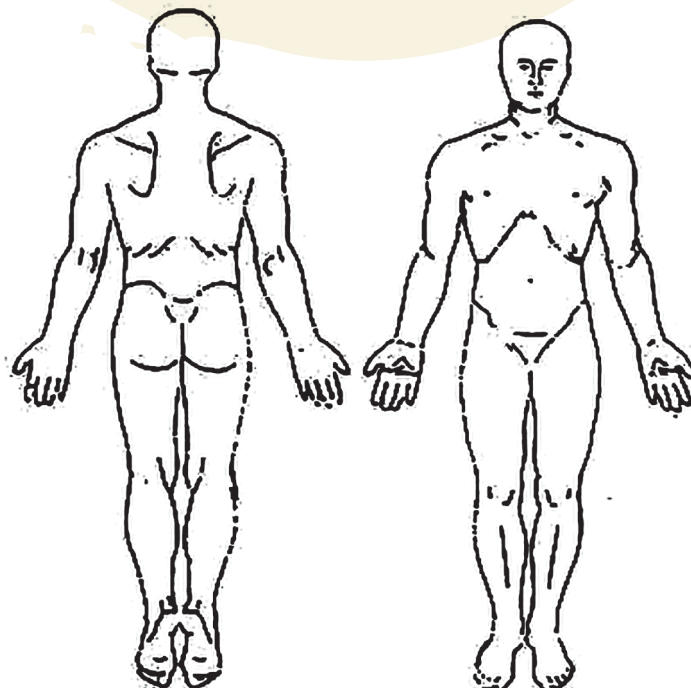
Please mark if you have had any of these conditions *(please include the date that the condition occurred)*

_____ Broken Bones	_____ Kidney disease
_____ Epilepsy	_____ Hepatitis
_____ High/Low Blood Pressure	_____ Headaches
_____ Diabetes	_____ Numbness in Extremities
_____ Heart Disease	_____ Respiratory Disorders
_____ Arthritis/Osteoporosis	_____ Fatigue
_____ Back Pain/Problems	_____ Anxiety
_____ Allergies/Sinus Problems	_____ Neck Pain/Problems
_____ Mood Swings	_____ Tuberculosis
_____ Thyroid Disorders	_____ Aneurysm
_____ Phebitis (blood clots)	_____ Skin condition
_____ Cancer Type _____	
_____ Aids/HIV Treatment _____	
_____ Pregnant Due Date _____	

Please list any surgeries (within the last 2 years) _____

What brings you here today? _____

Please circle problem areas.



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Check all that apply and rate the level of pain experienced (1 is the least, 10 is the most)

I experience pain:

	Daily	Weekly	Occasionally (When?)	
Ankles	_____	_____	_____	1 2 3 4 5 6 7 8 9 10
Arms	_____	_____	_____	1 2 3 4 5 6 7 8 9 10
Back	_____	_____	_____	1 2 3 4 5 6 7 8 9 10
Feet	_____	_____	_____	1 2 3 4 5 6 7 8 9 10
Hands	_____	_____	_____	1 2 3 4 5 6 7 8 9 10
Head	_____	_____	_____	1 2 3 4 5 6 7 8 9 10
Hips	_____	_____	_____	1 2 3 4 5 6 7 8 9 10
Joints	_____	_____	_____	1 2 3 4 5 6 7 8 9 10
Legs	_____	_____	_____	1 2 3 4 5 6 7 8 9 10
Muscles	_____	_____	_____	1 2 3 4 5 6 7 8 9 10
Neck	_____	_____	_____	1 2 3 4 5 6 7 8 9 10
Other	_____	_____	_____	1 2 3 4 5 6 7 8 9 10

Have you ever participated in or received

	Daily	Weekly	Occasionally	When or Where
Guided Imagery	_____	_____	_____	_____
Hypnosis	_____	_____	_____	_____
Hypnotherapy	_____	_____	_____	_____
Meditation	_____	_____	_____	_____
Relaxation	_____	_____	_____	_____
Acupuncture	_____	_____	_____	_____
Breathwork	_____	_____	_____	_____
Craniosacral	_____	_____	_____	_____
Energy Work	_____	_____	_____	_____
Massage	_____	_____	_____	_____
Tai Chi	_____	_____	_____	_____
Yoga	_____	_____	_____	_____

Please describe what you are here for: _____

