



**Client Intake Form--Hypnotherapy**  
*(All information will be kept confidential)*

Name: \_\_\_\_\_ Name you like to be called: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex:  Female  Male

Marital Status:  Single  Married  Partnered  Divorced  Widow/Widower

Children:  Yes  No If yes, please specify number of children: \_\_\_\_\_

Occupation: \_\_\_\_\_

Level of Education:  High School  College  Graduate work  Other \_\_\_\_\_

In case of emergency contact:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Presently on medication?  No  Yes If yes, please specify kind and amount: \_\_\_\_\_

Within the last year, have you taken (or has a health professional advised you to take) any prescription medication or drug that: a) affects your mental processes or mood; or b) treats a "chemical imbalance"?

No  Yes If yes, please specify type of medication and reason: \_\_\_\_\_

Any chronic or major illnesses or physical limitations?  No  Yes If yes, please specify:

General health: \_\_\_\_\_ Do you smoke?  No  Yes If yes, how much? \_\_\_\_\_

# Hampton Roads Hypnosis & Meditation, LLC



Rebecca Eldridge, CHT • 100 Bridge Street, Hampton, VA 23669 • (757)968-7365 • rebecca@hrhypmed.com

Have you undergone psychotherapy/analysis?  No  Yes From: \_\_\_\_\_ To: \_\_\_\_\_

For what reason(s): \_\_\_\_\_

Have you ever been hospitalized for mental breakdown or illness?  No  Yes If yes, please include details (diagnosis and medications--use additional paper if necessary): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Have you had any seizures?  No  Yes Do you have epilepsy?  No  Yes

Any adverse reactions to guided imagery?  No  Yes

Any fears or phobias?  No  Yes If yes, please specify: \_\_\_\_\_

\_\_\_\_\_  
How did you learn about Hampton Roads Hypnosis & Meditation? \_\_\_\_\_

\_\_\_\_\_  
Check here if you do NOT wish to be included on our mailing list \_\_\_\_\_

----- Payment Info -----  
*Please complete this section if you are paying by Credit Card*

Credit Card Type (check one) :  Visa  MasterCard  American Express  Discover

Name as it appears on your credit card : First name : \_\_\_\_\_

Last name : \_\_\_\_\_

Credit Card Number : \_\_\_\_\_ Expiration Date (month/year) : \_\_\_\_\_

Card Security Code : \_\_\_\_\_

Billing Address : Street : \_\_\_\_\_

City : \_\_\_\_\_

State : \_\_\_\_\_ Zip Code : \_\_\_\_\_

Home Phone (including area code) : \_\_\_\_\_

E-mail Address for payment notification (required) : \_\_\_\_\_

*Note : The charge will appear on your credit card statement as "HRHYPMED"*