3201 Highfield Drive
Suite M
Bethlehem, PA 18020

AMA
COUNSELING SERVICES, LLC

Tel. 610-419-1536
E-mail: AmaCounseling@gmail.com

# Hypnosis Intake Form

Name: _____ Date: _____

What is your primary reason or goal for today's visit? _____

_____

**Below is a list of common concerns that lead people to seek professional assistance. Please check all that apply to you**.

___ Anxiety/Stress
___ Insomnia
___ Nightmares
___ Depression
___ Weight Issues
___ Medical Issues
___ Surgical Anxiety
___ Poor health
___ Chronic Pain
___ Inability to relax
___ Compulsive tendencies

___ General Fears
___ Fear of Public Speaking
___ Fear of heights
___ Lack of Motivation
___ Low Self-Esteem
___ Phobic Reactions
___ Inability to focus attention
___ Relationship Issues
___ Sexual Dysfunction
___ Childhood trauma
___ War trauma

___ Smoking
___ Sports Performance

___ Alcohol/Drug Use
___ Test Anxiety
___ Unwanted Habits
___ Nail Biting

___ Poor memory
___ Goal Setting
___ Death of a loved one

Relevant Medical Condition/s: _____

_____

Are you currently on any medications? _____

_____

Are you currently under a physician's care for these conditions? YES NO

Date of your last visit with your physician: _____

Physician Name: _____ Phone: _____

**Note: If the reason for today's visit has to do with a medical issue, it will be necessary to obtain your physician's approval to use hypnotherapy as an adjunct to medical treatment.**

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Are you currently under the care of a mental health professional? YES NO

Name: _____ Phone: _____

Why are you seeking hypnosis: _____

_____

_____

Have you ever been hypnotized before? YES NO

Do you meditate? YES NO

Briefly describe your spiritual or religious beliefs or life philosophy: _____

_____

_____

How did you learn of our practice? _____

_____

Please answer the following Questions:

1. List three of your favorite colors: _____
2. Name three of your favorite places: _____
   _____
3. List three of your most important lifetime goals: _____
   _____
4. List three of your pastimes or hobbies: _____
   _____
5. List things that you like to do but would like to do better: _____
   _____
   _____
6. If you could what would you wish or, become or do? _____
   _____
   _____
7. One thing I feel guilty about is: _____
8. I am happiest when: _____
9. What makes you frightened? _____
10. If I were not afraid to be myself I would: _____
    _____
11. I get so angry when: _____
12. I am most saddened by: _____

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13. All of my life I: _____
    _____
14. Ever since I was a child I: _____
    _____
15. One of the ways I could help myself but I don't is: _____
    _____
16. Mention your most significant memory, experience, or event in your life: _____
    _____
    _____
17. What behaviors get in the way of your happiness? _____
    _____
    _____
18. What would you like to start doing? _____
19. What would you like to stop doing? _____
20. What motivates you? _____

21. Please explain any other negative conditions affecting you: _____
    _____
    _____
22. Please list any additional needs or concerns: _____
    _____
    _____
    _____