



A Positive Approach
to Dynamic Change

New Client Intake Form

Client Name: _____ Date: _____

Personal Information

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email address: _____

Marital Status: Single Married Partnered Divorced Widowed

Date of Birth: ___ / ___ / ___ Occupation: _____ Nbr of Children: _____

Emergency Contact: _____ Phone: _____

How did you find out about Positive Dynamics / Debbie? _____

If you were referred, who referred you? _____

Client Objectives

Challenge (check all that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> Addiction(s) | <input type="checkbox"/> Immune System Support | <input type="checkbox"/> Self Confidence |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Sports Enhancement |
| <input type="checkbox"/> Dental | <input type="checkbox"/> Medical (Referred) | <input type="checkbox"/> Smoking Cessation |
| <input type="checkbox"/> Fear(s) | <input type="checkbox"/> Mental Block | <input type="checkbox"/> Stress Mgmt |
| <input type="checkbox"/> Grief / Loss | <input type="checkbox"/> Motivation | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Habits | <input type="checkbox"/> Negative Emotions | <input type="checkbox"/> Weight Loss |
| <input type="checkbox"/> HypnoBirthing | <input type="checkbox"/> Pain Mgmt | <input type="checkbox"/> _____ |
| <input type="checkbox"/> IBS | <input type="checkbox"/> Relationships | <input type="checkbox"/> _____ |

Desired Outcome(s)

Background Information

Are you currently experiencing, or have a history with any of the following:

- | | | |
|---|--|---|
| <input type="checkbox"/> Abuse | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Poor Self Esteem |
| <input type="checkbox"/> ADD / ADHD | <input type="checkbox"/> Hair Pulling | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> SAD |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Inability to Relax | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Bi-polar Disorder | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Suicidal Thoughts |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Lack of Energy | <input type="checkbox"/> Teeth Grinding |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Nightmares | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Dissociative Identity Disorder | <input type="checkbox"/> Poor Memory | <input type="checkbox"/> _____ |

Current Medical / Psychological Care

List conditions for which you are currently being treated:

Medical: _____

Psychological: _____

List all medications including herbal and vitamin supplements:

Medication	Reason for Use
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Primary Health Care Provider: _____

History & Preferences

Past Experiences with:

- Hypnosis Neuro-Linguistic Programming Emotional Freedom Technique
 Meditation Reiki Acupuncture _____

Do you have any religious preferences or affiliations? If so, please briefly describe:

Do you have a fear or dislike of:

- Stairs, escalators, or elevators Water, oceans, rivers, or lakes
 Drifting, floating, sinking _____

Which environments are most relaxing for you:

- Nature, forest, parks, trails Quiet secluded places
 Sights & sounds of water Sporting & recreational activities
 Favorite vacation _____

Do you have any questions?

Consent

The hypnotherapy services provided by Debbie Nesbitt, RN, CH are not intended to replace medical or psychological therapies. There are no guarantees or promises of any specific results. All hypnosis is considered to be self-hypnosis. You, as the client, have the ability and responsibility to share any concerns and questions with the Hypnotherapist during your visit.

Do you consent to be hypnotized? Please initial the appropriate space:

_____ Yes _____ No

Would you like to receive the Positive Dynamics E-newsletter? Yes Not at this time

Would you like to receive periodic updates on classes, services, products, and special offers?

Yes No