CLIENT INFORMATION & HISTORY

Airó Hypnosis 13740 Research Blvd,
Building N. Ste. 8 - Austin, TX 78750 - www.shehypnotizes.com

Please fill out this form prior to our first session. All information you provide here is held to the highest standard of confidentiality. Leave blank any question you would rather not answer.

Client Name _____

Address _____ City_____ Zip Code _____

Phone number: _____ Phone Service Provider: _____ May I leave a message? _____

Age _____ Birthdate ____/____/_____ Email Address: _____

Name(s) & age(s) of child(ren)_____

Emergency contact: _____Relationship _____ Phone # _____

Who referred you to me? _____ May I thank this person for the referral? Y / N

Employer/Occupation _____

Employment Status: □ Full-time □ Part-time □ Choose to stay at home □ Unemployed

Are you happy at your current position? _____

Please list any work-related stressors: _____

Primary goal or reason for today's session? _____

_____

_____

How will your life be different when you reach your goal? _____

_____

_____

Other problems or goals, which may possibly be included in today's session or a future session _____

_____

_____

Are you currently receiving psychiatric care or psychotherapy? □ Yes □ No

If Yes, with whom? _____

Are you currently taking prescribed psychiatric medication (antidepressants, etc)? □ Yes □ No

If Yes, please list: _____

Please list medications taken in the past: _____

Have you ever been hospitalized for psychiatric reasons? □ Yes □ No

If yes, describe: _____

Have you thought about or attempted suicide? □ Yes □ No

If yes, please describe: _____

HEALTH AND SOCIAL INFORMATION

Please list any persistent physical symptoms or health concerns: _____

_____

Current medications: _____

Primary care physician: _____ Phone # _____

Are you having any problems with sleep? _____ _____

What are your exercise habits? _____

Are you having any difficulty with appetite, weight or eating habits? □ Yes No

If yes, describe: _____

Do you smoke or use tobacco? □ Yes □ No Please describe: _____

Do you drink alcohol? □ Yes □ No Please describe: _____

Do you use other/recreational drugs? □ Daily □ Often □ Rarely □ Never □ Not any more

If at all, please describe: _____

Have you ever experienced a concussion or other head injury? If yes, list date(s) and information known:

_____

Current relationship status: Single | Dating | Separated | Living together | Married | Divorced | Widowed

If applicable, please describe the quality of your current relationship: _____

_____

Please describe your relationship history: _____

_____

What of the following have you experienced or noticed in yourself in the **past year**? (check all that apply)

Chronic Pain or Illness
Educational Problems
Family or Parenting Conflict
Financial Problems
Grief/Loss
Legal Problems
Loneliness
Major Life Change
Other (specify): _____

Concentration or Memory Difficulty
Compulsive or Impulsive Behaviors
Restlessness
Sexual Dysfunction
Social Discomfort/Shyness
Identity Confusion
Spiritual Confusion
Trauma or disturbing life experience

FAMILY & MENTAL HEALTH HISTORY:

Check if Yes		Who?
	Depression	
	Bipolar Disorder	
	Anxiety Disorders	
	Panic Attacks	
	Schizophrenia	
	Addiction	
	Eating Disorders	
	Learning Disabilities	
	ADHD	
	Trauma/Abuse History	
	Suicide Attempts	

Briefly describe your relationship with your:

Mother: _____

Father: _____

Sibling(s): _____

Extended family: _____

Child(ren): _____

Do you consider yourself to be religious? _____ If yes, what is your faith? _____

If no, do you consider yourself to be spiritual? _____

What do you consider to be your strengths? _____

_____

What do you like most about yourself? _____

_____

How do you typically cope with problems in your life? _____

_____