

## IDENTIFYING INFORMATION

*Please provide the following information for our records. These responses are to help you get the most out of your therapy or hypnotherapy and will remain confidential.*

**Name:** \_\_\_\_\_  
(Last) (First) (Middle Initial)

**Name of parent/guardian (if you are a minor):**

\_\_\_\_\_  
(Last) (First) (Middle Initial)

**Birth Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Age:** \_\_\_\_ **Gender:** ☐ Male ☐ Female

**Social Security Number** \_\_\_\_\_

**Marital Status:** \_\_\_\_\_ **Number of Children:** \_\_\_\_\_

☐ Never Married ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

**Local Address:**

\_\_\_\_\_  
(Street and Number)

\_\_\_\_\_  
(City) (State) (Zip)

**Home Phone:** \_\_\_\_\_ May I leave a message? ☐ Yes ☐ No

**Cell/Other Phone:** \_\_\_\_\_ May I leave a message? ☐ Yes ☐ No

**E-mail:** \_\_\_\_\_ May we email you? ☐ Yes ☐ No

*\*Please be aware that email might not be confidential.*

**Emergency Contact :** \_\_\_\_\_  
Name Phone Number

By providing an emergency contact, you are giving me permission to speak with this person about your care in an emergency.

**Referred by:** \_\_\_\_\_

## HEALTH AND SOCIAL INFORMATION

**1. How is your physical health at present?** (Please circle)

- ☐ Very good    ☐ Good    ☐ Satisfactory    ☐ Unsatisfactory    ☐ Poor

**2. Have you had previous psychotherapy?**

- ☐ Yes, at Previous therapist's name \_\_\_\_\_  
☐ No

**3. Are you currently under the care of a physician for a physical or mental health condition?**

Please list **any persistent physical or emotional symptoms or health concerns** (e.g. chronic pain, headaches, hypertension, diabetes, depression, anxiety, etc.) and the physician in charge of treating that condition:

- ☐ Yes  
☐ No

Please List:

For What Condition?	Physician's Name?	Medication?	Dosing
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**4. If no, have you been previously prescribed psychiatric medication?**

- ☐ Yes    ☐ No    If Yes, please list: \_\_\_\_\_

Name of prescribing physician \_\_\_\_\_

**5. Please list any persistent physical symptoms or health concerns** (e.g. chronic pain, headaches, hypertension, diabetes, etc.) and the physician in charge of treating that condition:

\_\_\_\_\_

**6.. Are you having any problems with your sleep habits?** ☐ Yes    ☐ No

If yes, check where applicable:

- ☐ Sleeping too little    ☐ Sleeping too much    ☐ Poor quality sleep  
☐ Disturbing dreams    ☐ Other \_\_\_\_\_

7. How many **times per week do you exercise?** \_\_\_\_\_

Approximately how long each time? \_\_\_\_\_

8. Are you having any difficulty with appetite or **eating habits?** ☐ No ☐ Yes

If yes, check where applicable: ☐ Eating less ☐ Eating more ☐ Binging

9. Have you had **significant weight change** in the last 2 months? ☐ Yes ☐ No

10. **Do you regularly use alcohol?** ☐ Yes ☐ No

In a typical month, how often do you have 4 or more drinks in a 24-hour period? \_\_\_\_

11. Frequency of **recreational drug use?** ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never

12. Have you had **suicidal thoughts recently?**

☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never

13. Have you had suicidal thoughts in the past? How Often?

☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never

14. Have you ever made an attempt at suicide or to hurt yourself?

☐ More than Once ☐ Once ☐ Never

15. Are you currently in a **romantic relationship?** ☐ No ☐ Yes

If yes, how long have you been in this relationship? \_\_\_\_\_

On a scale of 1-10, please rate the quality of your current relationship? 10 is the best. \_\_\_\_\_

16. In the last year, have you had **any significant life changes or stressors?** ☐ Yes ☐ No

**Please Name Them** \_\_\_\_\_

17. **Have you ever experienced:** (Please Circle)

Extreme depressed mood YES or NO

Wild Mood Swings YES or NO

Rapid Speech YES or NO

Extreme Anxiety YES or NO

Panic Attacks YES or NO

Phobias YES or NO

Sleep Disturbances YES or NO

Hallucinations YES or NO

Unexplained losses of time YES or NO

Unexplained memory lapses    YES   or   NO

Alcohol/Substance Abuse    YES   or   NO

Frequent Body Complaints    YES   or   NO

Eating Disorder    YES   or   NO

Body Image Problems    YES   or   NO

Repetitive Thoughts (e.g., Obsessions)    YES   or   NO

Repetitive Behaviors (e.g., Frequent Checking, Hand-Washing) YES   or   NO

Homicidal Thoughts    YES   or   NO

Suicide Attempt    YES   or   NO

#### **OCCUPATIONAL INFORMATION:**

18. Are you currently employed? ☐ YES   ☐ NO

19. If yes, who is your **current employer/position**? \_\_\_\_\_

20. If yes, How would you **rate your satisfaction** with your current job?

\_\_\_\_\_ **Rating between 1 and 10—10 is the best**

21. Please list any work-related stressors, if any: \_\_\_\_\_

#### **RELIGIOUS/SPIRITUAL INFORMATION:**

22. Do you consider yourself to be religious? ☐ YES   ☐ NO

If yes, what is your faith? \_\_\_\_\_

If no, do you consider yourself to be spiritual? ☐ YES   ☐ NO

## FAMILY HISTORY:

23. Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (Circle any that apply and list family member, e.g., Sibling, Parent, Uncle, etc.):

### Difficulty/Problem

### Family Member

Depression YES or NO

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Bipolar Disorder YES or NO

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Anxiety Disorders YES or NO

---

Panic Attacks YES or NO

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Schizophrenia YES or NO

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Alcohol/Substance Abuse YES or NO

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Eating Disorders YES or NO

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Learning Disabilities YES or NO

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Trauma History YES or NO

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Suicide Attempts YES or NO

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## 24. Other issues or areas you would like to resolve: (Please Circle)

\* Situational Stress /Anxiety

\* Forgiveness

\* Guilty or Angry Feelings

\* Relationship Issues

\* Fears, Phobias or Trauma Recovery

\* Job Performance

\* Low Self Esteem or Shyness

\* Smoking Cessation

\* Body Shape

\* Sports Performance

\* Spiritual Growth

\* Self Confidence

\* Test Taking/Accelerated Learning/Memory Improvement

\* Chronic Pain (already assessed by a physician)

\* Health issues (already assessed by a physician)

Other: \_\_\_\_\_

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How committed are you to reaching your goals, on a scale of 1-10....where 10 is the most committed?

How committed are you to overcoming any obstacles or challenges, on a scale of 1-10...where 10 is the most committed?

# HYPNOTHERAPY AGREEMENT

Hypnotherapy and Self-hypnosis are not absolute sciences. I understand that Gloria Waite, Licensed Psychologist and Board Certified Hypnotherapist, is a facilitator in my hypnosis experience and that my involvement in my therapy is **equally important**.

**In order to be more successful in reaching my goals, I agree to:**

1. Be an active participant in my hypnotherapy experience and see myself as a partner in the transformative nature of this process.
2. Apply the information that I discover in the sessions to become a healthier and happier human being.
3. Take responsibility for the experience of my thoughts, feelings, images and actions—realizing that they have a direct impact on the quality of my life..
4. Acknowledge that my well-being depends directly on how well I care for myself physically, emotionally, intellectually and spiritually.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Legal Guardian:** \_\_\_\_\_ **Date** \_\_\_\_\_

If under eighteen years of age:

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**I am professionally committed to HELP YOU ACCESS YOUR INNER RESOURCES AND USE THEM TO CREATE PEACE OF MIND, HEALTH AND HAPPINESS IN THE SHORTEST POSSIBLE TIME.**

\_\_\_\_\_*Gloria J Waite*\_\_\_\_\_Date: ***Date of First Session***

**Gloria J. Waite, M.A., M.F.T.  
Licensed Psychologist  
Board Certified Hypnotherapist**