Synergy Wellness Center

Client Intake Form

Name**:** _____ Age: _____ Marital Status: _____

Emergency Contact Name & Phone: _____

Tell me about your treatment history:
Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? ( ) yes ( ) no

Have you had hypnosis or therapy before? If yes, please describe:
_____
_____
_____

Are you currently on any mind-altering substance (pharmaceutical or otherwise)? If so, please list: _____

Tell me about your health and lifestyle:
Please list any physical symptoms or health concerns: _____
_____
_____

Are you currently under a physician's care for any above conditions? Yes No

Last physician appointment date: _____

Are you having any problems with your sleep habits? If yes, check where applicable:
( ) Sleeping too little ( ) Sleeping too much ( ) Poor quality sleep
( ) Disturbing dreams ( ) other _____

Approximately how often per week do you exercise? How long each time?___

Are you having any difficulty with appetite or eating habits? If yes, check where applicable: ( ) Eating less ( ) Eating more ( ) Bingeing ( ) Restricting

Have you experienced significant weight change in the last 2 months? ( ) no ( ) yes

Check all substances ingested in your average week ( ) Sugar ( ) Caffeine ( ) Alcohol ( ) Marijuana ( ) Opioids ( ) Pharmaceuticals ( ) Plant Medicine ( ) Other _____

Do you have any thoughts of hurting yourself or taking your life? Yes No

Do you have any thoughts of hurting someone else? Yes No

Do you have any spiritual/religious belief or life philosophy?

Tell me about your family:

Has anyone in your family (either immediate family members or relatives) experienced challenges that affect you now or have in the past?

_____
_____
_____
_____
_____

_____

Tell me about your occupation and level of satisfaction:

Are you currently employed? If yes, are you happy with your current position?

_____

Please list any work-related challenges or goals: _____

_____

_____

Tell me about your religious and/or spiritual beliefs:

Do you meditate? ( ) Sometimes ( ) Yes ( ) No

Briefly describe your spiritual or religious beliefs or life philosophy (most importantly your preferred terminology): _____

_____

Tell me about your life:

What is your romantic relationship status? _____

What is your happiness or satisfaction level? _____

In the last year, have you experienced any significant life changes or stressors? If yes, please explain: _____

_____

_____

What do you consider to be your strengths? _____

_____

_____

What do you like most about yourself? _____
_____

What are effective coping strategies that you have learned? _____
_____
_____

What are your goals for this session?
_____
_____
_____

Please identify other areas or issues you would like to resolve:

( ) Situational stress	( ) Guilt/anger	( ) Fear/anxiety
( ) Self esteem/confidence	( ) Lack of motivation	( ) Body shape
( ) Forgiveness	( ) Unwanted habits	( ) Smoking cessation
( ) Sports performance.	( ) Spiritual growth.	( ) Chronic pain
( ) Accelerated healing	( ) Test taking/accelerated learning	

If you are altering a habit or behavior pattern, please take this space to list every time, association, and trigger that is a regular friend to that behavior. This will start the reframing process: _____
_____
_____
_____
_____
_____