Synergy Holistic Health Center
7309 US Hwy 42, Suite 1, Top Floor, Florence, KY 41042
(859) 525-5000 | www.synergyholistichealth.com

Clinical Hypnotherapy | NLP | Coaching

Intake Form

Date:_____

Name: _____

Name you prefer we use: _____

Date of Birth: _____ Age: _____ Sex: F ☐ M ☐

Address: _____

City: _____ State: _____ Zip:_____

Phone Number (___)_____ (___)_____ (___) _____
Home Cell Work

E-Mail Address: _____

Occupation: _____ SS#: _____

Healthcare Provider: _____

Do you visit your doctor regularly: _____ For what? _____

Please list all medical conditions you have _____

_____

Please list all medications that you take _____

_____

Drug Allergies: _____

How did you hear about me? Friend/Family(who)_____

☐ Internet ☐ Yellow Pages ☐ Other:_____

Emergency Contact Name: _____ Phone: _____Relationship:_____

By signing this form I give my consent to receive input at Synergy including NLP Coaching, Hypnotherapy, Trance Work, and Craniosacral. I understand this work is guided by a certified practitioner. I understand I may discontinue a session at any time. I realize that the treatment is given for the well-being of my mind and body. All information will be kept in strict confidence. My information may be shared among practitioners at Synergy. I have stated all medical conditions that I am aware of and will update the therapist(s) and practitioner(s) of any changes in my health status.

Signature: _____ Date:_____

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Please mark if you have had any of these conditions *(please include the date that the condition occurred)*

_____	Broken Bones	_____	Kidney disease
_____	Epilepsy	_____	Hepatitis
_____	High/Low Blood Pressure	_____	Headaches
_____	Diabetes	_____	Numbness in Extremities
_____	Heart Disease	_____	Respiratory Disorders
_____	Arthritis/Osteoporosis	_____	Fatigue
_____	Back Pain/Problems	_____	Anxiety
_____	Allergies/Sinus Problems	_____	Neck Pain/Problems
_____	Mood Swings	_____	Tuberculosis
_____	Thyroid Disorders	_____	Aneurysm
_____	Phebitis (blood clots)	_____	Skin condition
_____	Cancer Type _____		
_____	Aids/HIV Treatment _____		
_____	Pregnant Due Date _____		

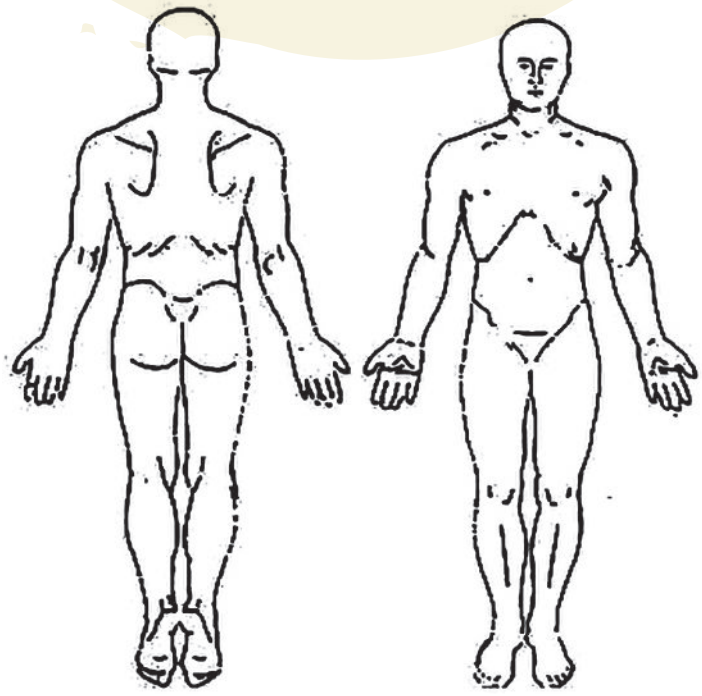
Please list any surgeries (within the last 2 years) _____

_____

_____

What brings you here today? _____

Please circle problem areas.



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Check all that apply and rate the level of pain experienced (1 is the least, 10 is the most)

I experience pain:

	Daily	Weekly	Occasionally (When?)	
Ankles	_____	_____	_____	1 2 3 4 5 6 7 8 9 10
Arms	_____	_____	_____	1 2 3 4 5 6 7 8 9 10
Back	_____	_____	_____	1 2 3 4 5 6 7 8 9 10
Feet	_____	_____	_____	1 2 3 4 5 6 7 8 9 10
Hands	_____	_____	_____	1 2 3 4 5 6 7 8 9 10
Head	_____	_____	_____	1 2 3 4 5 6 7 8 9 10
Hips	_____	_____	_____	1 2 3 4 5 6 7 8 9 10
Joints	_____	_____	_____	1 2 3 4 5 6 7 8 9 10
Legs	_____	_____	_____	1 2 3 4 5 6 7 8 9 10
Muscles	_____	_____	_____	1 2 3 4 5 6 7 8 9 10
Neck	_____	_____	_____	1 2 3 4 5 6 7 8 9 10
Other	_____	_____	_____	1 2 3 4 5 6 7 8 9 10

Have you ever participated in or received

	Daily	Weekly	Occasionally	When or Where
Guided Imagery	_____	_____	_____	_____
Hypnosis	_____	_____	_____	_____
Hypnotherapy	_____	_____	_____	_____
Meditation	_____	_____	_____	_____
Relaxation	_____	_____	_____	_____
Acupuncture	_____	_____	_____	_____
Breathwork	_____	_____	_____	_____
Craniosacral	_____	_____	_____	_____
Energy Work	_____	_____	_____	_____
Massage	_____	_____	_____	_____
Tai Chi	_____	_____	_____	_____
Yoga	_____	_____	_____	_____

Please describe what you are here for: _____

_____

_____

_____