

Hypnosis Columbia LLC
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Relapse Prevention & Addiction Freedom Intake

Date: _____

Name _____ Home Phone _____

Address _____ City, State, Zip _____

Date of Birth _____ Marital Status _____ # of children _____

Current Occupation _____ Education Level _____

Emergency Contact _____ Phone _____

Name/phone number of doctor providing referral or clearance for hypnosis treatment:

Do we have permission to discuss your goals with your doctor (above)? Y N

Are you currently seeing a mental health practitioner (including a psychiatrist)? Y N

Name _____ Phone _____ *Initials* _____

Name _____ Phone _____ *Initials* _____

Name _____ Phone _____ *Initials* _____

Please initial above for mental health practitioner we are allowed to confer with about your case.

Do you have any serious medical issues? Explain _____

Are you currently taking any medications? Please elaborate _____

Have you ever been treated for the following? (✓ for Yes) Heart ___ Diabetes ___ Epilepsy ___ Pain ___

Have you ever been treated for depression or other mental health issue? Y N

Issue/Diagnosis _____

What medications are you taking and why? _____

Have you ever thought about, planned or attempted suicide? Y N

If yes, please explain _____

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Goals and Desired Outcomes

Describe your goals and desired outcomes as pertaining to the following. Please use clear, affirmative language. Focus on what you WANT versus what you do not want.

General _____

Body/health _____

Daily habits/routines _____

Family/Relationships_ _____

Personal Success _____

Mental/Emotional _____

Spiritual _____

Other _____

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History of Substance Use

Name of Drug	Quantity/Dosage Day	How long?	Last Use?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Is there a history of alcohol or substance abuse in your family? Explain _____

When did you first start using alcohol or substances? What age? And, primary reason?

What other needs/purpose has alcohol or substances served for you in the past?

Do you tend to drink or use the same time of day? Explain _____

Have you ever tried to hide your drinking or use? Explain _____

What negative consequences have you experienced due to your alcohol or substance use?

Primary reason(s) for quitting your current alcohol or substance use? _____

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History of Substance Cessation/Treatment

Have you ever tried to quit or alter use before? Y N Explain _____

Why did you start using again? _____

Have you ever experienced any of the following when you tried to stop drinking and/or using?

- Seizures Tremors Nausea/Vomiting Hallucinations Loss of Consciousness
 Hot/Cold Sweats Blackouts Falls?

Please list any treatment programs you have attended, including outpatient programs, and psychiatric treatment programs:

Name of Program	Dates	Purpose of Treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever been through Detox? Y N Explain. _____

What is your longest period of sobriety? _____

What were some of the obstacles in achieving and maintaining long term sobriety?

What was most resourceful and helpful at rehab/treatment centers? How long did you remain clean after rehab/treatment? _____

What other things helped you to obtain or maintain sobriety? _____

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Ever attended 12-Steps or SMART Recovery groups? What did you like or dislike about them?

Triggers and Risk Factors

Does anyone in your immediate family currently use alcohol or substances? Y N

Please name all your triggers or associations you have with alcohol and substance.

Please relate any concerns, fears or possible obstacles for you in achieving your goal today. _____

Please relate any history of trauma (childhood, teenage, adult, etc.) or experiences that still bring you an emotional charge when you think about them. _____

If you could let go of certain recurring thoughts, feelings, self-limiting beliefs (e.g. “I am not good enough”) – what would they be? Provide as much or as little detail as you would like.

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If you would forgive yourself or others for any past experiences or perceived shortcomings, who would you forgive, and for what? Provide as much or as little detail as you would like.

Benefits

Name 5-7 benefits you will achieve when you reach your goals or desired outcome? Imagine what success will feel like, look like, etc. Perhaps include some things you are looking forward to (better health, enhanced social life, improved relationships, sense of confidence, etc.).

Strengths & Resources

Name at least three of your strengths (for resources in accomplishing your goals).

Name at least three things you are grateful for today. _____

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What are some of your favorite activities? _____

What do you do for relaxation? _____

Where and when do you feel the safest? _____

Do you have any spiritual practices? Explain. _____

RELEASE STATEMENT

By signing this, I understand that hypnosis and hypnotherapy are not a substitute for medical or psychological care or medication. Hypnosis is not meant to diagnose or treat any disease, but rather it is intended to provide information, education and motivation which will help an individual to feel better and achieve behavioral goals faster. It is designed to give me insight and tools into my innate healing potential and guide me into being more effective in helping myself reach a desired outcome.

*I have been encouraged to advise my doctor and/or seek the advice of a licensed health care provider, with regard to treating me for specific medical or psychological issues. I hereby authorize Hypnosis Columbia LLC to hypnotize me for the purposes outlined in this intake form and for future purposes that I may request. I understand that the success of my hypnosis sessions depends greatly on my own ability and desire to participate to create change in myself. I understand that the practice of hypnosis and hypnotherapy is not an exact science. I understand that Hypnosis Columbia LLC cannot offer any guarantee of the success of my treatment, nor are refunds given for services rendered. I am aware, however, that Hypnosis Columbia LLC will do everything in its power to ensure my success. I do hereby release and discharge Hypnosis Columbia LLC and its associates from all claims of responsibility of damages, and of responsibility from alleged damages arising from or growing out of my participation in hypnosis and any tools, techniques or programs sponsored by Hypnosis Columbia LLC. Also, I understand that audio and video recordings may be made during sessions and that Hypnosis Columbia retains all rights to these recordings. **By signing this form, I am stating that I have read this form and understand all of its contents.***

Printed Name _____ Date _____

Signature _____ Date _____

Parent Name (if above under 18) _____ Date _____

Parent Signature _____ Date _____