

## Clinical Hypnosis of Southern Maine

21 Donald Dean Drive  
South Portland, ME 04106  
(207) 874-9859

Note: All information will be kept strictly confidential except that which Clinical Hypnosis of Southern Maine is legally obliged to report, such as threat of injury to yourself or others. If you are in any way uncomfortable with any of these questions, feel free to skip them. Please be aware that the more you tell me about yourself the more I may be of assistance to you. I appreciate your trust.

Name \_\_\_\_\_ Date of birth \_\_\_\_\_ Gender \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Day phone \_\_\_\_\_ Evening phone \_\_\_\_\_ Cell \_\_\_\_\_

Are you being treated by a psychotherapist/psychiatrist? Yes \_\_\_ No \_\_\_

If yes, for what? \_\_\_\_\_

Please list any medications or supplements you take \_\_\_\_\_

Why are you seeking hypnotherapy? \_\_\_\_\_

Are you currently experiencing any of the following? (Please check ALL that apply.)

nervousness  inability to relax  sleeplessness  depression  sexual dysfunction  
 compulsive tendencies  nail biting  teeth grinding  nightmares  poor health  
 cigarette smoking  alcohol abuse  drug abuse  compulsive overeating  
 self-mutilation  eating disorder  codependency  inability to focus attention  
 poor memory  relationship problems  recent divorce  childhood trauma  
 war trauma  current illness or death of loved one  fear of heights  lack of energy  
 poor self-esteem  abusive home situation  ADD/ADHD  abusive work situation  
 lack of success  other: \_\_\_\_\_

RELEASE STATEMENT: I hereby authorize Patti Rutka Stevens, CH, to hypnotize me for the purposes outlined in this intake form and for other purposes that I may request verbally. I understand that the success of my hypnosis session depends greatly on my own ability to relax, and the desire to create change in myself. I understand that because the results of my sessions depend greatly upon my own serious participation that Patti Rutka Stevens, CH, cannot offer any guarantee of the success of my treatment. I am aware, however, that Patti Rutka Stevens, CH, will do everything reasonably in her power to ensure my success. I accept that I may be billed if I cancel my session with less than 24 hours' notice.

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