



## Enlightened pathways healing center CLIENT INTAKE QUESTIONNAIRE

Date: \_\_\_\_\_

All information given on this questionnaire will be kept strictly confidential.

Please complete the form below.

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: M F

Address: \_\_\_\_\_

Occupation : \_\_\_\_\_

Daytime Phone:(\_\_\_\_) \_\_\_\_\_ Evening Phone:(\_\_\_\_) \_\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_\_

E-mail: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Name of Spouse or Partner: \_\_\_\_\_

Name & ages of Children: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

1. List Three Favorite Colors: \_\_\_\_\_

2.. List Three Favorite Places: \_\_\_\_\_

\_\_\_\_\_

3. What is/was your relationship like with your mother?: \_\_\_\_\_

\_\_\_\_\_

4. What is/was your relationship like with your father?: \_\_\_\_\_

\_\_\_\_\_

5. On vacation, do you prefer relaxation or excitement? \_\_\_\_\_

6. List any fears or phobias: \_\_\_\_\_

7. Do you suffer any compulsive tendencies? \_\_\_\_\_

8. List any current health problems: \_\_\_\_\_

9. List any medications you are taking? : \_\_\_\_\_

10. Please list your three most important lifetime goals:

\_\_\_\_\_  
\_\_\_\_\_

11. Please state the reason(s) you are seeking Hypnotherapy:

\_\_\_\_\_

12. Please state or list the goal and/or outcome you would like to achieve from your Hypnotherapy session(s)?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

13. If you could be, do, have or become anything, what would you wish for?

\_\_\_\_\_

14. Why are you seeking Therapy?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

15. How did you hear about Enlightened Pathways Healing Center?

\_\_\_\_\_

***If there is any other information not asked above that you would like to share please elaborate below:***

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_

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**Release:**

I understand that my success depends on my own commitment to improving the situation which brings me here. I realize that Melissa Watts is not prescribing for, or treating any physical or mental ailments, and do not hold her responsible for them. I release her from any liability whatsoever regarding my session. I agree to inform Melissa of all physical or mental conditions which might affect her work. I understand that our sessions may involve healing touch. I authorize that this release form apply to all future appointments as well. I agree to pay the full fee for any appointment canceled with less than 24 hours notice, emergency situations excluded.

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

I Melissa Watts agree to use the best of my abilities to help you make the changes you seek and treat you with care and respect. I agree to give you my undivided attention and professional assistance during our scheduled sessions, and I agree to strict confidentiality.